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COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

January, 1998

Volume 95, Number 1

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On the matter of Managed Care... Where are we?

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TURNING?
CHILLS?
STOMACH PAINS?

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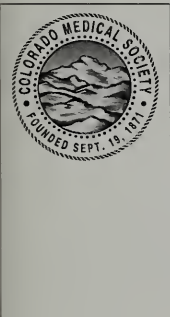
On the matter of
Managed Care...
Where are we?

Cover Story

Manage care, where are we, where have we come from, where are we going? Thoughts from an expert on the other side of the fence and notes from the front line.

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<http://www.cms.org>

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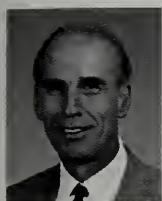
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Gary D. VanderArk, MD
President, 1997-1998

But officer, I'm not a crook

The problem of health care fraud and abuse raises issues that are fundamental to the nature of professionalism. I was totally flabbergasted to read that the U.S. Department of Justice has declared that health care fraud and abuse is the second most important enforcement issue facing the federal government. Only violent crime is rated higher.

Am I naive or ignorant? Are they talking about us? Were you surprised that in 1997, Colorado was one of nine states receiving grants for a new program in health fraud investigation? Are you aware that through last year's Kennedy-Kassebaum legislation that one billion dollars has been appropriated to investigate health care fraud and abuse over the next five years?

Well, what do they mean by fraud and abuse? The Medicare and Medicaid regulation define "fraud" as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit. Fraud is intentional misconduct. "Abuse" is a term that describes a much broader and less well-defined range of conduct. Abuse is characterized in the Medicare and Medicaid regulations as incidence or practices that are inconsistent with accepted medical practice such as actions that result in program payments for medically unnecessary services where facts are not intentionally misrepresented in order to obtain payment.

Well, how big a problem are we talking about? A July 1997 report on the financial statement audit of the Health Care Financing Administra-

tion (HCFA) by the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) provides a typical example of the lack of clarity in discussing fraud, abuse and waste. The OIG reviewed 5,314 claims processed for 600 Medicare beneficiaries during FY 1996 and, by projecting these results to all claims filed, estimated total overpayments of \$23.2 billion. While the OIG specifically stated that the allegedly improper payments were due to conduct that ranged from honest mistakes to outright fraud, it could not quantify the portion attributable to deliberate fraud. Nevertheless, the media and certain members of Congress linked the \$23.2 billion in estimated losses to intentional misconduct by physicians, hospitals and other health care providers.

Most of the estimates of the total dollar value associated with fraudulent and abusive health care practices in the United States have been speculative at best and are often based on extrapolations from high profile fraud settlements and fraud demonstration projects. The 1997 OIG report discussed above continued in this vein. Accordingly, the American Medical Association has advocated more definitive studies that will yield credible data to allow for a better understanding of the actual scope of the problem, as well as to better focus anti-fraud activities and strategies. As a recent example of the difficulty in determining the prevalence of health care fraud, the General Accounting Office (GAO) stated in its 1996 report, entitled

(Continued next page)

"How big of a problem are we talking about?"

(President's Letter continued)

Health Care Fraud: Information Sharing Proposals to Improve Enforcement Efforts, that "the amount of fraud within the health care system is, by its nature, impossible to accurately determine". Nevertheless, the GAO continues to estimate that as much as 10% of all health care expenditures may be lost to fraud and abuse.

Recent health care anti-fraud efforts have focused on those segments of the health care market that have experienced relatively rapid growth: home health care, hospice care, nursing home care, durable medical equipment and supplies, and managed care.

Well, how big a problem is fraud and abuse in Colorado? There are, in Colorado, 16,000 Medicare Part B providers. During the calendar year

of 1996, there were a total of 155 investigations in Colorado. Of these total investigations, 0.04% were referred. I assume that referred means that there was some substance to the allegations. I would assume that from this incidence of cases that, at least in the past, fraud and abuse have not been significant problems in Colorado. Nevertheless, I think this is an area that demands the attention of all providers. The Colorado Medical Society seeks to be your ally in this problem.

I would, therefore, make the following recommendations to all Colorado physicians:

- 1) I would urge all physicians to renew their commitment to our principles of medical ethics which means that "a physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in

character, competence or who engage in fraud or deception.

- 2) I would urge all physicians to make no intentional misrepresentations to increase the level of payment they receive or to secure non-covered health benefits for their patients.
- 3) I would urge all physicians to report investigation to the Colorado Medical Society so that we can be your ally in dealing with Big Brother, and so that we can be the repository of data to document how big a problem fraud and abuse claims are within our physician membership. To that end, if and when you have been notified of investigation concerning possible fraud and abuse, please notify Edie Register or Marilyn Rismiller in the CMS offices at (303) 779-5455 or 1-800-654-5653.



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CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax[®]
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

BME issues new statement on physician-patient relationship

The Colorado Board of Medical Examiners (BME) recently issued the following policy statement concerning the physicians-patient relationship.

Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are:

- Open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in his or her care.
- Commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician's personal interests.
- Provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more or less.
- Avoidance of any conflict of interest or inappropriate relationships outside of the therapeutic relationship.

The relationship between a physician and a patient is fundamental, and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns is and must be secondary to the fundamental relationship.

Any act or failure by a physician that violates the trust upon which the relationship is based may place the physician at risk of being found in violation of the Medical Practice Act.

POLICY: A Colorado physician has both medical-legal and ethical obligations to his or her patients. These are well established in both law and professional tradition. The prevailing model of medical practice, as it is implemented by some plans, may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that the procedures in question do not adversely affect the care that they render to their patients.

Resolutions due for 1998 CMS Interim Meeting

The Colorado Medical Society (CMS) Interim Meeting will be held on March 14-15, 1998, at the Denver Marriott SE, I-25 and Hampden.

Speaker of the CMS House of Delegates, Louise McDonald, MD, reminds you that in order to allow ample time to review and compile information for the House of Delegates Handbook, all Resolutions and Reports must be received in the CMS offices no later than January 20, 1998.

Please contact your component society president if

you are interested in serving on two probable reference committees, the Board of Directors/Constitution & Bylaws/ Credentials and the Health Affairs Reference Committees. If activity warrants, additional reference committees will be formed. Physician names must be received by January 12, 1998. Because of multiple nominations from all of the components, we cannot choose every name submitted. Please note that reference committee members serve at the Interim Meeting and the Annual Meeting.



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Liquidated Damages Provisions in Professional Employment Contracts May Not Be Enforceable

Liquidated damages clauses in professional employment contracts between physicians are not uncommon. Some clauses, such as those discussed below, provide for the payment of damages to the professional corporation if a physician sets up a competing practice in a given area following termination, while others compensate the corporation for loss of goodwill. Whether a damage provision in a professional employment contract is valid and enforceable depends upon the nature, amount and duration of payments required under the contract and their relationship to the actual harm suffered by the former employer. When the liquidated damages do not reasonably relate to the actual harm to the employer, they will not be enforced.

Covenant not to compete provisions in employment, partnership and corporate agreements between physicians, which restrict the right of a physician to practice medicine upon termination of such an agreement, are void and unenforceable under Colorado law. However, "provisions which require the injury suffered by reason of termination of the agreement, shall be enforceable. Provisions which require the payment of damages upon termination of the agreement may include, but not be limited to, damages related to competition." Section 8-2-113(3), Colorado Revised Statutes 1997.

A recent Colorado appellate court decision examines the enforceability of liquidated damages clauses in one such contract and holds that the provisions are not enforceable.

Dr. A entered into an employment agreement with a professional corporation which provides that Dr. A "shall be free to engage in the practice of medicine in competition with the Company, except upon so competing with the Company, the Employee shall be obligated to pay the Company damages related to that competition in an

amount reasonably related to the injuries suffered by the Company by reason of such competition." The agreement further provides that Dr. A must pay the professional corporation liquidated damages if his employment terminates for any reason and he continues to practice within a 25-mile radius of Greeley, Colorado during the two-year period following termination. Under the noncompetition provision, Dr. A must pay as liquidated damages for harm to the corporation's profitability, fifty percent of the fees he generates from practicing in competition with the corporation for two years after termination. The trial court found that the intended purpose of this noncompetition provision was "to discourage termination of employment without departure from the area."

The goodwill provision provides that: "To compensate the Company for the harm to its goodwill, its position as a service provider and for its lost training time and effort, the Employee shall pay the amount of Ten Thousand Dollars (\$10,000) and shall immediately forfeit any amount that might otherwise be due the Employee as Deferred Compensation..."

After Dr. A terminated his employment the professional corporation attempted to enforce the contract. Dr. A sought a declaratory judgement that the liquidated damages provisions are invalid and unenforceable. Although both parties agreed to the damages provisions contained in the contract, the statute permits enforcement of those provisions only as to damages "reasonably related to the injury suffered by reason of termination of the agreement."

After hearing extensive evidence, including expert testimony, on the issue of actual damages, the trial court determined that the liquidated damages portions of the goodwill provision were not enforceable because the professional corporation suffered no harm to its goodwill and had provided no termination. Consequently, such damages were not reasonably related to the professional corporation's actual injury, and the liquidated damages provision of the goodwill provision would not be enforced.

On the other hand, the trial court determined that the amount of the contractual, liquidated damages under the noncompetition provision was reasonably related to the amount of damages the corporation would suffer by virtue of Dr. A's departure and competition with the corporation. Therefore, Dr. A was contractually bound to pay fifty percent of the fees he generated from practicing in competition with the corporation for two years after termination.

Both parties appealed. The interpretation of a contract by a trial court is a matter of law which the appellate court examined the evidence presented to the trial court and disagreed with its decision finding the noncompetition provision enforceable. The appellate court determined instead that the net profits of the corporation and its shareholders remained essentially the same as they were prior to the termination of Dr. A's

(Continued next page)

(Damages continued from page 2)

employment. Thus, the noncompetition provision of the contract, which required Dr. A to pay fifty percent of his fees to the professional corporation for two years, provides for damages that are not "reasonably related to the injury suffered" by the corporation by reason of the termination of its contract with Dr. A. Consequently, the appellate court reversed, holding that the language of the noncompetition provision specifying the amount of the damages was invalid and unenforceable under the statute.

The appellate court affirmed the trial court's determination that the goodwill provision was invalid and unenforceable.

Finally, with respect to both the goodwill provision and the noncompetition provision, the court of appeals held that the liquidated damages were so disproportionate to any possible loss incurred by the professional corporation as to constitute an unenforceable penalty at common law.

This case illustrates an example of over-stepping, miscalculation, or wishful thinking by the professional corporation which resulted in the complete invalidation of the liquidated damages provisions. The Court will not reform the contract to provide liquidated damages to the corporation which approximate the actual damages suffered by the professional corporation, if any. Instead, the clause intended to discourage termination of employment without departure from the area, fails in both respects to discourage the competitive practice and to compensate the professional corporation for its loss.

Citation: Wojtowicz v. Greeley Anesthesia Services, P.C., 96CA604, decided November 28, 1997.

Send us your calender items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, have them send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include information detailing program sponsor, date, location and phone number for more information.

AACMS demonstrates strong support for CROP

Hats off to the Aurora-Adams County Medical Society (AACMS) for their continuing strong show of support for the Colorado Rural Outreach Program (CROP). Over \$2,500 was raised through the sale of raffle tickets for a travel package gift certificate. Congratulations go out to Dr. Barry Sundland who won the raffle. Dr. Sundland will enjoy \$1500 worth of travel to be used any way he wishes! The drawing was held at the AACMS annual holiday party on December 5. All proceeds from sales of raffle tickets and door prize tickets benefited CROP.

AACMS also made a separate donation of \$1,700 to CROP. Many thanks to AACMS and all the people who supported this effort by both purchasing and selling the tickets!

New Medicare E & M Documentation Guidelines postponed

Medicare has postponed implementation of the new E & M documentation guidelines until July 1, 1998 (based on the date of service). Physicians now have an extra six months to become comfortable with the new documentation requirements. That does not mean that you are off the hook, Medicare will continue to do audits. However, those audits will be based on the E & M documentation guidelines published in 1994. Physicians who are ready to begin using the new E & M guidelines may do so as they exceed the old requirements. The Medicare carrier mailed the new guidelines in November 1997. If you did not receive a copy, please contact Marilyn Rissmiller in the CMS Health Care Financing Department at (303) 779-5455 or 1-800-654-5653, ext. 2428.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Expanded Learning

"Espanol Rapido" for health care providers
January 22-23, 1998
Denver, Colorado
(303) 333-3445

Colorado Springs Memorial Hospital

4th Annual Pediatric Symposium
The Challenge: ADD/ADHD & Learning Disabilities
January 24, 1998
Colorado Springs, Colorado
8.8 Category I AMA credit hours, AAFP applied for,
Contact: Jan Hodge (719) 365-5675

Colorado Hospital Association

Paying for TeleHealth: New Developments Towards
Financing Networks and Reimbursement of Services
February 2, 1998
Denver, Colorado
Contact: Peggy McCreary (303) 758-1630

National Jewish Medical & Research Center

20th Anniversary National Jewish medical & Research
Center Update on Allergy, Asthma & Clinical Immunology
February 4-8, 1998
Keystone, Colorado
Contact: (303) 398-1000 or e-mail at proed@njrc.org

Colorado Hospital Association

JCAHO: health Care Network Accreditation Standards
and Survey Process: Mastering the Basics
February 11, 1998
Englewood, Colorado
Contact: Peggy McCreary (303) 758-1630

American College of Cardiology

Cardiovascular Conference at Snowbird
February 11-14, 1998
Snowbird, Utah
18.5 Category 1 AMA
1-800-253-4636, ext. 695

Medical Education Resources

Dermatology for the Non-Dermatologist
February 13-15, 1998
Breckenridge, Colorado
11 credit hours in AMA Category 1, 11 credit hours for
American Academy of Family Physicians
Contact: Linda Main (303) 798-9682 or 800-421-3756

Colorado Society of Osteopathic Medicine

Ski & CME Midwinter Conference
February 22-27, 1998
Keystone Lodge & Resort, Colorado
38 hours AOA Category 1-A, AAFP prescribed course
hours; AAPA credits
Contact: Patricia Ellis (303) 322-1752 or 1-800-527-4578

American College of Cardiology

5th Annual Echocardiographic Workshop on 2-D
Doppler Echocardiography at Vail
February 23-26, 1998
Vail, Colorado
18 Category 1 AMA
1-800-253-4636, ext. 695

American Lung Association

17th Annual big Sky Pulmonary & Critical Care Medi-
cine Conference
March 25-28, 1998
Big Sky Montana
(406) 442-6556

Colorado Hospital Association

20th Annual Rural Hospital Conference
April 29-May 1, 1998
Breckenridge, Colorado
Contact: Peggy McCreary (303) 758-1630

American College of Cardiology

Clinical Cardiology Mgmt. and Diagnostic Dilemmas
April 29-May 1, 1998
Santa Fe, New Mexico
16 Category 1 AMA
Contact: 1-800-253-4636, ext. 695

Colorado Society of Osteopathic Medicine

Annual Meeting
July 24-26, 1998
Vail, Colorado
18 hours AOA category 1-A
Contact: Patricia Ellis (303) 322-1752

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director

Bright and perky, always seems to be "Up" carrying much more of a load than her size would dictate, but never seeming to let it slow her one bit.

That pretty well describes Ellen Stein, the Director of Health Care Policy Division at CMS for a long time. She's been with the firm for 12 years, but now she is about to leave.

It is difficult to say nice things about someone when you are, in a sense, angry at them for announcing that they are leaving for greener pastures, and yet you have appreciated them so much in the organization. With Ellen it is doubly difficult. She has been an excellent team member and administrator. She has been well liked by her staff associates, employees and the many health care professionals with whom she has worked. Someone else has realized her value and has offered her an opportunity to further spread her wings.

Effective January 12, Ellen will assume the position of Executive Director of **Safehouse Denver**, a 30-bed shelter for victims of domestic violence and their children. She has worked long and hard on the issue of domestic violence, creating a year-long program to bring awareness to physicians on how they can help domestic violence victims. She has caused several of the specialists within the domestic violence prevention campaign to write articles for **Colorado Medicine**, and which have opened many eyes to a

major nationwide psycho-social program.

For all this we are appreciative, but Ellen, there's still more we could do if you'd just stick around!

Fortunately, CMS will continue to work on informing its membership about the domestic violence problems, and so we don't lose her altogether.

CMS has already begun the long and arduous task of finding a replacement for Ellen Stein, and it will be no easy task. To actually replace her, we will need a young, aggressive person with the street smarts of a Chicago social worker, the charm of a society "princess," the grace and movement of a ballerina, the heart of a person twice her size, twice her age, and the cunning of a loving 3-year-old child. She'll need all this to know how to get things done!

Her replacement also has to genuinely like people of all kinds; Ellen has shown this trait in everything she has done, being an effective lobbyist, an advocate for patients and physicians alike, and champion for the many medically and socially underserved in our population.

This is going to be a tough act to follow, even though a lot of her traits Ellen learned right here on the job. She has had a lot of help from fellow workers, physicians and physician spouses and associated health care professionals. We are delighted that she will have the opportunity to further prove herself, but are we ever going to miss her.

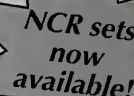
Best wishes, Ellen, from all of us here at Colorado Medical Society.

"... the street smarts of a Chicago social worker. . . the grace and movement of a ballerina..."



Ellen Stein, Director
CMS Health Care Policy

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advocating excellence in the profession of medicine.*



*Christopher Unrein, DO, Chairman
Council on Legislation*

The legislature convened on January 7, 1998. By the time you read this article, many of the bills listed here will have been introduced. You can see by the length of the list that this will be an extremely busy session. We certainly are going to need the assistance of the CMS membership to inform legislators of our reasons for support or opposition of the bills.

CMS leadership, component society executives and Key Contacts will automatically be informed of actions on all high priority measures, but we ask that you contact the CMS Department of Government Relations if you also want this information first-hand. You need only call Government Relations staff at 1-800-654-5653 or 779-5455, Ext. 410 or 427 and furnish us with your name and fax number. Updates and "Alerts" on high priority bills will be sent to you on a regular basis. Legislative information is also posted on the CMS Internet Home Page:

**Go to www.cms.org
select "Heard on the Hill."**

The Council on Legislation met on December 3 and heard presentations from the Colorado Chiropractic Society and several pharmacists regarding prescriptive authority for those groups. After careful consideration of the proposals, the Council voted to oppose both bills. Dr. Dennis Chalus presented the telemedicine bill draft which the Colorado Radiological Society will be introducing. It was agreed that CMS will work with the Radiological Society on language for the bill.

1998 Expected Legislation As of 12/17/97

- Increase in license fees for CPHP (Epps)
- Chiropractic prescribing (Musgrave)
- "Hold harmless" clause in managed care contracts (Epps)
- Pharmacist prescription privileges ("collaborative services")
- Abstinence only education
- Six Interim Committee bills on "no fault" auto coverage plus one by Senator Tebedo on a fee schedule for treatment of auto accident victims
- Inappropriate dilation and extraction (partial-birth abortion) constitutes unprofessional conduct (Morrison)
- Needle exchange program
- Pharmacy tech licensing (ratio of techs to pharmacists)
- Narrow therapeutic index bill
- PERA employee health insurance
- Children's Health Care (grants, etc.)
- Prohibition of Physician Assisted Suicide (Tebedo)
- Resolution reflecting CMS Policy on Euthanasia (Morrison)
- For-profit conversions by health care organizations
- Telemedicine (Wham)
- Prohibition on smoking in motor vehicle carrying children under 16 years
- Repealing Governmental Immunity for physicians practicing at UCHSC
- Mandatory Benefits:
 - 1) Bone density Screening
 - 2) TMJ "All joints are equal"
- Reduction of mandatory auto insurance coverage from \$50,000/\$50,000 to \$5,000/\$5,000 (Viega)
- Freedom of choice of health care provider (Matsunaka)
- Constitutional amendment allowing public hospitals to be in joint ownership, shareholders or members with private persons and entities (CHA)
- Marijuana for Medicinal Use
- Managed Care Liability (Kreutz)
- Allowing for faxed prescriptions for Hospice patients (Morrison)
- Codification of 48/96 hour delivery (Morrison)
- Creation of Colorado Health Care Task Force (Morrison)
 - 1) Look at the Big Picture
 - 2) Provide Institutional Knowledge in wake of term limits

NOTE: See "List of Legislators" on following page.

SAVE THIS and the following pages – listing the members of the 1997 Colorado Senate and House of Representatives, their mailing addresses and telephone numbers. These lists are published for the purpose of the Colorado Medical Society Government Relations Division Key Contact program. These contacts will be of vital importance to Colorado physicians during 1997. We urge you to **locate your district legislators and keep these numbers handy.**

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(Continued next page)

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HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - November 21, 1997

Copic: Dr. Buckley stated that Copic now has 4427 insured physicians, 14 insured hospitals, and 27 insured medical entities. He also said that Copic has two new competitors in Colorado; CMA and St. Paul. Copic has a very liberal disability/retirement policy for their insured physicians, and a "suspension in premium coverage", which in the case of illness, will reduce the premium to 1%. Copic is developing three new products for their insureds; disability, telemedicine, and a patient satisfaction questionnaire. Copic would like CMS to join them in a combined project to make the questionnaire available to Colorado physicians.

Colorado Department of Health: Dr. Steve Lowenstein is the new Chief Medical Officer at the Colorado Department of Health. One of the issues Dr. Lowenstein began working with was HB 1139, which would have amended the Medical Practice Act and made repeated, unnecessary prescribing of antibiotics subject to medical discipline. The Health Department is now working on an antibiotic task force. The task force is going to provide more information to providers regarding over-prescribing of antibiotics, and consumer expectations/knowledge is another approach the task force is taking. For the Health Department's Annual Fall Campaign, Dr. Lowenstein hopes that besides stressing the need for flu shots, they will also stress the importance of pneumococcal vaccinations, and the careful use of antibiotics. The Health Department is studying the issue of suicide. A task force will be developed to study evidence based suicide. The Health Department is also writing new HMO Regulations.

CMSA: Ms. Stella Shanks stated that the Alliance's emphasis in October was on stopping America's violence. Leadership training sessions were held in Chicago during the month of October. The next leadership training will be held in February. During the leadership training there will be a one day session for County Membership Chairs. The State Alliance has offered to pay for any County Membership Chairs who wish to attend. Starting in December, the CMSA will be conducting a fund raising effort for the AMA Education and Research Foundation.

AMA Delegation: Dr. Richert Quinn stated that the delegation is preparing to go to the AMA Interim Meeting (IM) in Dallas, Texas. He stated that Dr. VanderArk will be making a presentation on Accountability during the AMA IM. The Colorado Delegation has submitted seven resolutions for consideration by the AMA House of Delegates. A couple of small, intimate dinners have been arranged in an attempt to gain support for Dr. Quinn's candidacy for reelection to Council on Constitution and Bylaws, and Dr. Joel Karlin's future candidacy for the AMA Board of Trustees.

The next Board Meeting will be held on January 23, 1998, at CMS.

So Who's Got Money To Burn These Days.

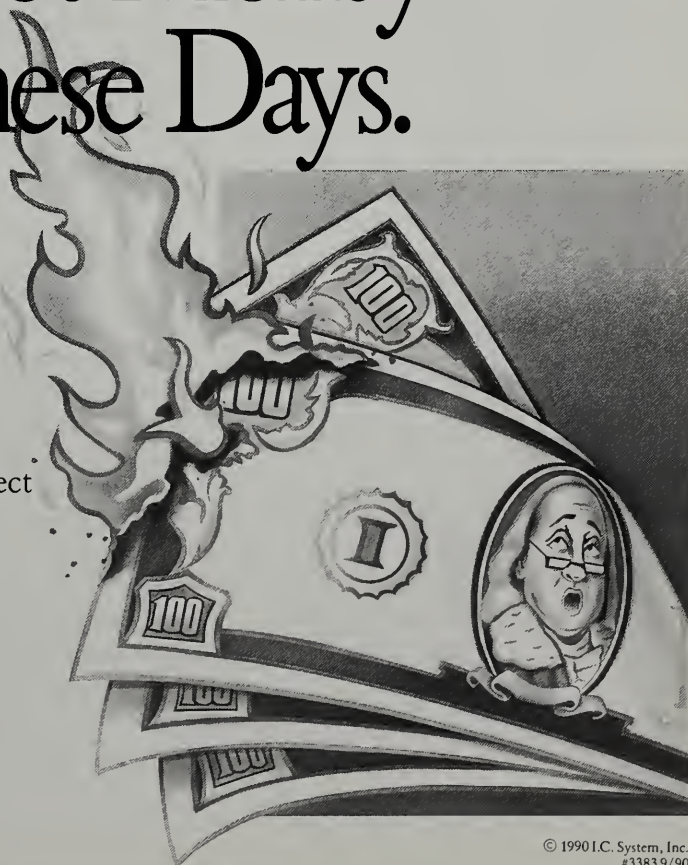
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here Is Managed Care Taking the Medical Profession? 1998 Follow-Up



by Leigh Truitt, MD
Medical Director, PacifiCare Colorado

"Does this sound like role reversal?"

One year ago I wrote in *Colorado Medicine* that the medical profession regarded managed care as an external force. I also predicted that we would see direct physician involvement in utilization review, physician developed compensation systems, and a trend away from proscriptive approaches to health care – you may not do this – and toward a prescriptive approach – you should do this.

As 1998 begins, all of my predictions are coming true except the last, prescriptive rather than a proscriptive approaches. PacifiCare, the HMO I work for, is moving to delegated, capitated care for most of Colorado. We believe that micromanagement by managed care organizations has stalled out; that further gains in cost effectiveness will only be possible by enlisting the energies of our physicians and other providers. Remember that the only alternative to lower utilization is lower fees.

Why should you as practicing physicians be concerned about the cost effectiveness of care? The managed care industry in Colorado is not healthy. For the first half of 1997, out of 20 HMOs, only four were profitable and some lost a great deal of money. Why not just raise premiums? Of all the PacifiCare states (predominantly in the West), Colorado has the highest premiums. We are at the top of the market. Commercial and governmental payers will not pay a great deal more for health care.

Can we lower utilization? The answer is yes but it will not be easy. Acute inpatient days in Colorado for

commercial plans are running at about 225 per thousand members per year. In California, many plans are at 150 to 180 days. In some states, commercial premiums are 80% of what they are in Colorado. Patient satisfaction, HEDIS indicators and other outcomes are not noticeably different in these states. Some managed care organizations in Colorado are also reporting higher days per thousand than they were several years ago. We can do better.

Other adverse factors are also present. In my current position in managed care, I have daily reminders of the march of technology. New procedures, new diagnostic modalities and new prescription drugs are constantly appearing – almost always better in some ways but seldom less expensive. Neither the public, legislators nor regulators are likely to allow us to ration these advances.

So how will we improve our cost effectiveness while still providing all necessary medical care? Most physicians believe that their practice is optimum from the standpoint of both costs and quality; that a few "bad apples" are the overutilizers of resources and the underachievers of health care quality. We are sure that we can deselect the outliers at the top end of the distribution of health care costs and solve the cost quality problems.

My belief is that this won't work for a number of reasons. First, today's outliers are not necessarily tomorrow's. At the individual physician level, there is a great deal of random variation because of small

(Continued next page)

numbers. Second, even the best of physician profiling systems cannot fully account for differences in severity of illness in physicians' practices. Third, most specialty designations do not fully reflect varying scopes of practice.

We must **all** improve – a day here, a day there. We must not substitute laboratory studies and imaging for thought. Practice guidelines, practice parameters, and

algorithms will help as long as considerations of cost effectiveness are incorporated.

You have asked to be in charge. Now you will have that opportunity. However, with responsibility goes accountability. When you are paying for care out of your own checkbook, you will be more thoughtful in terms of utilization. We in managed care organizations will also expect you to guard against underutilization. Our

challenge will be to assure consistency of benefits and all necessary care within the promised benefits on behalf of our membership.

Does this sound like role reversal? It does to me. I am confident, however, that physicians will continue to do everything in their power to provide that care that their patients need. Ready or not, here it comes!

Feedback FROM THE FRONT LINES

We asked CMS members what they think about their role and the role of managed care organizations. Is managed care doing what it is supposed to do? Is it positive or negative for patients and the economy? What are the advantages of such a system? Has the practice of medicine been affected? What is your principle problem with managed care? What do you like most? Answers follow:

Managed care has allowed more people to have health insurance coverage through their employers. There are pros and cons. It has been more positive for patients than physicians and hospitals. The system pits primary care doctors against specialists, and pits all physicians against hospitals in certain situations. The problem I see is that we're in the middle of the changes that managed care has created. The pressure to lower cost has affected attitudes throughout the system and it's going to get worse before it gets better.

– R. Douglas Yajko, MD
General Surgeon, Glenwood Spgs, CO
Member, CMS Board of Directors

Basically we are learning to live with it. It's not a comfortable situation to let managed care organizations dictate how and when we can see patients, which

ultimately determines the care they receive. However, I am encouraged. I'm encouraged because patients are becoming more aware about what is going on. I'm convinced that as consumers become more informed, things will change for the better.

– Alfred N. Carr, MD
Otorhinolaryngologist, Longmont, CO
Member, CMS Board of Directors

In my long-term care practice, Medicare managed care does a reasonably good job to the point that patients enter a nursing home. Once in the home, the concept of "Pods" and other systems and principles conflict to make care confused and complicated. Many times I have seen families choose to revert to regular Medicare versus Medicare managed care because the system works better. Managed care has a difficulty with understanding the difference between primary care physicians (PCPs) in a clinical setting and PCPs

in a nursing home setting. Gatekeeper issues become confused because the clinical PCP must refer to the nursing home PCP. Further referrals to specialists must come from one or both PCPs, who do not always understand or concur with diagnoses and regimens of care. This has led to dissatisfaction amongst patients and their families.

I think over time the system will correct itself. Some Medicare managed care companies are becoming more interested in making effective change. It's just now that these companies are discovering how to best serve and manage long-term care patients.

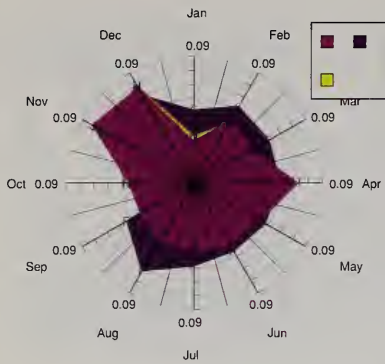
– Robert D. McCartney, MD
Internist, Denver, CO
AMA Alternate Delegate

Managed care has given me a good excuse to retire.

– Anonymous



The 1998 Legislative Session has begun. Upcoming elections, campaign finance reform and term limits will add to the already spirited nature of lawmaking. Join COMPAC today and help strengthen the voice of medicine at the Capitol. Call Lorraine Koehn or Suzanne Hamilton at (303) 779-5455 or 1-800-654-5653.



Critical Appraisal of Studies of Health Outcomes

John F. Steiner, M.D., M.P.H.
Associate Professor,
University of Colorado Health Sciences Center

A clinician/scientist's view

"A high-quality outcomes study should provide information that directly helps us care for our patients....Common sense and clinical judgement should guide us."

As physicians and health care organizations become increasingly accountable for measuring the outcomes of care, we must all become more sophisticated evaluators of health outcomes studies. We need to become more adept at critical appraisal of outcomes studies in the published literature. We also need to evaluate carefully the internal studies generated by our own organizations, and to pay increasing attention to the design of the outcomes studies we plan to conduct. Five considerations should guide our interpretation of the published outcomes literature and our own work.

I. Clinically sensible study questions and outcomes

An outcomes study should begin with a clearly defined question of immediate clinical relevance: does a disease management program for asthma improve the quality of life of the patients who receive it? does a treatment strategy for peripheral artery disease improve patients' functional capacity? do standing orders for adult or childhood immunizations improve immunization rates in a clinic? The outcome measures as well as the question should be clinically applicable. Since physicians typically use patients' symptoms and self-reported function to guide their clinical decisions, outcomes studies should incorporate rigorous measures of these clinical phenomena. For example, an asthma study should assess patients' dyspnea, cough, or exercise capacity and not simply pulmonary function tests, while a study of PAD should assess walking ability in the community,

and not just blood flow to the affected limb. (Regensteiner et al, 1996) A high-quality outcomes study should provide information that directly helps us care for our patients.

II. Appropriate data sources

As we select data sources for our own outcomes studies, or evaluate the published literature, we should remember that accurate data sources may not be easily available, while easily available data sources may not be accurate. It is tempting to rely on administrative data, such as billing claims, when designing an outcomes study. On reflection, many problems with administrative data become evident: the information is entered by clerical staff who may have little incentive to accuracy; the data may lack or inaccurately record crucial clinical information (think of the way you enter ICD-9 codes on your outpatient "superbill"); changes in the coding of information may occur over time but not be documented, and so on. It is wise to limit the use of administrative data bases to the purposes they are best suited - tracking utilization of services, ancillary tests, or pharmaceuticals and estimating costs.

Medical records provide more clinical detail for outcomes studies than administrative data. If we use medical records as a data source, however, we must remember the problems which have plagued us in reviewing records since we were third-year medical students. The records may be unavailable, incomplete, illegible or contradictory. (Do you believe a third heart sound was

present if the intern was the only one to record it, or only if the attending physician noted it?) Information may be stored in strange places - in unfiled sheets or out of chronological sequence. Records selectively fail to document certain types of clinical transactions, such as counseling, prevention, mental health problems or social concerns.

Increasingly, outcomes studies are using patient questionnaires to broaden the range of clinical variables that can be assessed. No blood test or radiograph can measure pain, satisfaction with care, or quality of life - we must rely on our patients to tell us these things. Since these outcomes are of substantial importance to our patients, we should make use of the increasing array of well-validated instruments which can help us assess them. We should work to overcome our discomfort and unfamiliarity with the use of questionnaires. At the same time, the problems with questionnaire data must also be kept in mind: selection of an inappropriate sample of patients, low response rates, the use of "leading" questions, the difficulty patients have in recalling remote events, the bias inherent in reporting behaviors (especially socially unacceptable ones), and the complexity of the concepts we are trying to assess.

All these data problems should not dissuade us from conducting

outcomes studies, but rather should increase our care in designing them, and should inject a note of healthy skepticism into our interpretation of them. We should be every bit as careful in designing and reading outcomes studies as we are in providing care. We need to remember the typical problems with these data sources, and assess how the authors of an outcomes study have addressed them, before incorporating the findings into our practice.

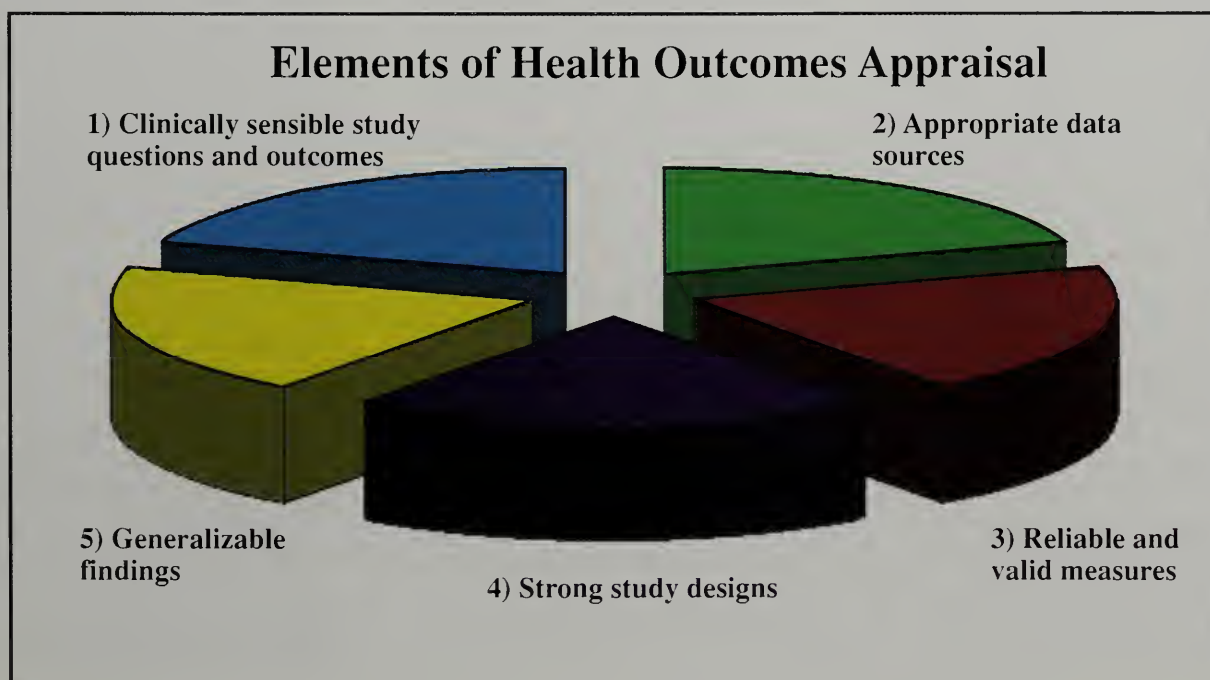
III. Reliable and valid measures

In outcomes studies, we need to measure (or make sure that the authors of published studies have measured) the correct variables, using the best data sources, with the appropriate instruments. Here again, common sense and clinical judgment should guide us. It is important to evaluate the content of a measure before using it in a study. For example, the SF-36 is a widely-used measure of health status which assesses multiple domains of physical, mental, and social functioning. (McHorney *et al.*, 1993) However, certain interventions may not affect all the domains measured by the SF-36. Is it reasonable to expect that an intervention for peripheral arterial disease will affect mental and social domains of health, or only physical function? If an improvement in physical function is the desired outcome of an intervention, a measure

of walking distance in the community may be better suited for an outcomes study than a "global" health status measure such as the SF-36. As a second example, many of the physical activities assessed in the SF-36 are vigorous, such as running, golfing, carrying groceries, walking long distances, and climbing several flights of stairs. These activities may be beyond the capacity of elderly patients or those with severe chronic diseases, and may not be amenable to improvement by interventions in these populations. In such cases, measures of less physically challenging activities of daily living may be more appropriate. If the measures chosen are less than optimal, the designers of the study should acknowledge the fact, and not "oversell" their conclusions.

In designing or reading studies, we should demand evidence of the reliability and validity of the clinical measures chosen. The reliability of a measure is essentially its ability to give the same results in the absence of clinical change. If two separate individuals review a medical record, do they obtain the same information from it? (Remember what a problem this was when you were a house officer, and your consultants found some important detail that you, in your fatigue, had overlooked). If a patient responds to a questionnaire

(Continued next page)



(Outcomes continued)

over time and in the absence of an intervention, are the responses consistent? The validity of a measure is its accuracy, its correspondence to the truth. Is a diagnosis of PAD in the medical records backed up by evidence of claudication, diminished pulses, a reduced ankle-brachial index, or an abnormal angiogram? Is a patient report of worse health status corroborated by increased use of health services? We can rarely be sure that our measures are valid - patients are too complex and measurement too difficult for there to be a perfect correspondence between measurement and truth. Nevertheless, we should maintain high standards for assessing reliability and validity in published studies and in our own.

IV. Strong study designs

Since 1993, JAMA has published an invaluable series of "Users Guides" to the medical literature, which have described in detail criteria for critical appraisal and use of a wide range of clinical studies. (Oxman *et al.*, 1993, Guyatt *et al.*, 1993, Naylor *et al.*, 1996, Guyatt *et al.*, 1997) This series reminds us to place the most reliance on studies with the strongest research designs, and to be more skeptical of studies with weaker designs. For example, randomized controlled trials provide the strongest evidence of the benefits of a treatment because they most successfully control for the effects of bias in making observations, and of unmeasured "confounding" factors which might also affect patient outcomes. However, the expense and logistics of a randomized trial often make such a design impossible for "real-world" outcomes studies. Instead, intervention studies may rely on "quasi-experimental" designs in which patients are assigned to treatment groups by strategies other than randomization (such as allocation of two clinics to different interventions). We may also try to understand the effects of different treatment strategies through careful measurement and follow-up of comparable patients receiving different

treatments using observational study designs such as prospective and retrospective cohort studies. (Kramer *et al.*, 1997) Since nonrandomized studies are more susceptible to bias and confounding, we must keep the strength of the study design in mind when we plan or evaluate an outcomes study, and must develop an instinctive caution about the conclusions of studies with weaker research designs. While such studies may show us the truth, we should require larger effects or more consistency across studies before incorporating their findings into our practice.

V. Generalizable findings

For all their advantages, it may be difficult to confidently extrapolate the findings of randomized trials to clinical practice. The rigorous exclusion criteria required to enroll patients into such studies may make their results generalizable to only a minority of patients in actual practice. For example, the studies which have shown that anticoagulation reduces the risk of embolic stroke in patients with atrial fibrillation have typically excluded patients at high risk of complications of anticoagulation, which may lead to an underestimate of the adverse effects of treatment. In practice, patients with atrial fibrillation often have some concurrent problem, such as a high risk of falling or bleeding, that makes the decision more difficult than the randomized trials suggest it should be. Thus, in reading or designing an outcomes study, it is important to ask: Are the patients in this study recognizably similar to my own? Has the study excluded women, elderly patients, individuals with comorbidity, or patients who might be intermittently noncompliant? If the spectrum of patients in an outcomes study is substantially different from the patients we care for, caution in application is in order even if the design is strong.

In conclusion, the move toward increased social accountability of the medical profession requires us to evaluate the outcomes of our care thoughtfully and accurately. Changes in our practice should be

guided by the best possible information about strategies to improve our patient's health, using a definition of health which includes functional status and quality of life as well as physiologic outcomes. The outcomes studies we conduct should be informed by the best evidence available from the literature. In both our own studies and our reading of this literature, we should define clinically sensible research questions, select appropriate data sources, use reliable and valid measures, choose the strongest feasible study design, and enhance the generalizability of the results by including representative patients. The care necessary to accomplish these tasks may slow down the pace at which we implement change and increase the costs of conducting such studies, but this process and these resources are an investment in results that meet the ultimate goal of serving our patients' health. In the long run, the most expensive data is bad data.

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CopicComment

by Jerome M. Buckley, MD
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Legislative Outlook

Physician advocacy - particularly in the legislative arena - has been one of Copic's primary roles since its founding. That role will take on increasing importance beginning in January, when the Colorado State Legislature opens the 1998 session. To help give you some perspective on the legislative issues likely to surface during the upcoming session, I've asked George D. Dikeou, Executive Vice President and General Counsel to Copic and head of our Legislative Committee, to draft the following article. I hope you find it helpful.

The next legislative session, which begins in January of 1998, may be one of the most critical legislative sessions for medicine in Colorado since 1986 when initial tort reform was successfully enacted. Several currents will come together during the 1998 session that could significantly alter how health care is delivered in Colorado for many years to come.

To begin, there is widespread public dissatisfaction with managed care, particularly with the public's perceived notion that efforts to manage cost have reduced access to physicians of choice, resulted in denial of

needed treatments and, in general, have interfered with the traditional physician/patient relationship. The current process of peer review, with its automatic grant of confidentiality and immunity, has led to a strong consumer movement to "open up" the peer review process to public oversight.

There will be increased efforts by the Colorado Trial Lawyers Association to modify and/or eliminate tort reform.

We will witness the initial impacts of term limitations on continued service by senior legislators. Many knowledgeable, experienced legislators who have historically understood the dynamics of the health care industry and the need for strong legislative oversight will be concluding their legislative service.

The elections scheduled for November 1998, will require those Representatives and Senators seeking re-election to be sensitive to their electability. This often increases uncertainty and predictability during the legislative session itself.

And finally, election reform will significantly impact the ability of enlightened interest groups to make their positions known to legislators.

Corporations cannot make direct contributions to legislators, and

individuals are limited to a total of \$200 each: \$100 of which may be contributed in a primary contest and \$100 for the general election.

Copic is permitted to engage in "educational informational" activities designed to increase the knowledge of the electorate. It is in this area where Copic can be of greatest service to health care in Colorado.

Copic will keep you informed of issues before the legislature and how those issues impact you. However, information alone will not be enough. Each of you must engage the system through your support of those legislators who recognize the correctness of your positions. In addition, you must be willing to participate actively in efforts such as letter writing, phone, fax and e-mail communications and other direct contact efforts designed to inform and gain support of your own legislators.

Copic will continue to play an active role at the Colorado legislature and we look forward to working with you to achieve results for the betterment of health care in Colorado.

It was a PARTY!

Though it may not have sounded like your typical office staff Christmas party, this one took on a special meaning before the day was out. Instead of the traditional "close the office, bring in the food and booze, pass out the gifts and go home" scenario, CMS staff this year elected to "give" a party for one of the "Head Start" classes in the inner-city.

We started out by selecting the class through the "Head Start" program coordinators based on a number of qualifying factors. Then we got the names of the students, all in the 3 to 4-year-old group, and a list of what each wanted most for Christmas. Staff members then went shopping and started wrapping and tagging the gifts for the group of 17 children.

For an additional party highlight, we rented a double-decker British bus that picked up the staff at CMS and then took us all to the school, at 25th and Curtis in the Five-Points section of Denver. As soon as we arrived, the children and their teachers and aides suited up and got on the bus for a 30-minute ride around downtown. The children delighted in waving to everyone, "seeing the sights" and singing Christmas carols in English and Spanish.



When the bus returned to the school, there was a lunch of pizza, carrots, celery, soft drinks and cupcakes for dessert waiting for the children. Many of the children had lots to say about a lot of things. Whatever the case, it was an exciting time for them and a fun time for CMS staff. We really had a party!

Next came the presents. Sorry. There were no pictures suitable for printing... they were all a blur of excitement as the children experimented with their new toys.



Kirsten Spilde of Colorado Physician Network and CMS Executive Director Sandi Maloney usher a couple of our students off the bus for lunch.

After playtime and hugs and "thank-you's" all around, CMS staff left a room full of excited children for their teachers to attempt to settle into naptime.



Ellen Stein, Director of Health Care Policy, was attempting to explain a point to these young ladies. Whatever the result, everyone was happy.



Chet Seward, CMS Communications, got into a serious discussion with this young man. He was busy showing Chet his new birthday shirt.

And what did these wonderful, caring teachers have to say? "It is worth it because it is all for the children!"

Following the school party, CMS treated our staff to lunch. It was a great day in the true spirit of the holiday.



Our Head Start students and their teachers and aides head off on an exciting bus ride through downtown Denver, singing Christmas songs and waving to everyone they passed. It was a British double-decker so they had a good view of everything.



After lunch, the students all had creative ideas how they would like to spend the rest of the day. Beth Crusha, CMS Membership, was immediately taken under the direction of this young lady who wanted (Beth) to relax for the afternoon reading and looking at pictures.



This discussion looked political, but no one ever interrupted it to ask. Lorraine Heth of CMS Health Care Policy was certainly captivated by the student's comments and commentary.

What's in the cards?

Not as important as what's ON the cards.

If you're like most Bridge players, you're always hoping for good cards. Well, here's one solution: These cards are always good! CMS, in celebration of its 125th Anniversary, has produced these Bridge decks, excellent for gifts or for your personal use, printed with the Colorado Medical Society seal in gold on a red back, they are Bridge size plastic coated linen cards.

They're just \$4.25 per deck including postage and handling. All proceeds go to the Colorado Medical Foundation, so this is one bridge hand that's a win-win-win situation. Order now!

You needn't be the "dummy" in this hand. Whether you play convention, tournament, Masters or social, you'll love these cards. Just mail the coupon below with your check. Supplies Are Limited! So Hurry!



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Colorado Medical Society

Special Insert

The federal government continues its efforts to trim the costs of administering the Medicare program. Medicare final rules for 1998 were published in the October 31, 1997 edition of the Federal Registry. A review of the important changes follow.

The CMS Health Care Financing Department is closely watching this year's round of Medicare reforms. Please review the Medicare reform information below. Then distribute it (the pages are perforated) to your office staff. Should you have further questions please contact Edie Register or Marilyn Rissmiller in the CMS Department of Health Care Financing at (303) 779-5455 or 1-800-654-5653.

January 1, 1998

Medicare payment and coverage changes

Payment Changes:

- **Conversion factors** - Beginning with dates of service 1/1/98 and after, Medicare will have one conversion factor for all primary care, nonsurgical and surgical services (instead of 3). That conversion factor is \$36.6873. This represents an increase for medical and nonsurgical services, but a decrease for surgery which had been at \$40.9603. The anesthesia conversion factor is \$16.8762.
- **Clinical lab fee schedule** - The cap on this fee schedule is being reduced from 76% of the national median to 74%. These fees will be frozen for four years.
- **Drugs and biologicals** - The allowable for injectible drugs provided in the physician's office will be reduced to 95% of the average wholesale price (AWP).
- **Non-physician practitioners** - The maximum allowable for services furnished by nurse practitioners (NPs), physician assistants (PAs) and clinical nurse specialists (CNSs) will be based on 85% of the physician fee schedule. Note: Medicare coverage for services provided by these practitioners has been extended to *all* settings permitted by state law.
- **Increase in the work relative value units (RVUs) for global surgical services** - The work RVUs were increased for surgical procedures which include pre and post-operative evaluation and management (E & M) visits by the surgeon within the global follow up period. This change was made to make them consistent with the 1997 increases in the work RVUs for E & M services.
- **Resource-based practice expense values** - Will be phased in over a four-year period. However, as of 1/1/98 the practice expense portion of some values will be reduced, and the corresponding savings redistributed to office visits. This reduction will apply to those services which are not performed in an office setting at least 75% of the time, and where the practice expense value exceeds the work value by more than 110% (this will affect about 700 codes).

Coverage Changes:

- **Screening mammogram** - Coverage has been expanded to allow annual screening mammograms for asymptomatic women over 39 years of age. The Part B deductible is waived. Note: Don't forget to use the new ICD-9 code V76.12.

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Medicare payment and coverage changes (continued)

- **Screening Pap smear and pelvic examinations** - In addition to a screening Pap smear every 3 years, Medicare will now pay for the pelvic examination (including a clinical breast exam). Annual coverage of the screening Pap smear and pelvic exam will be allowed for women (1) at high risk of cervical or vaginal cancer, or (2) of childbearing age who have had a Pap smear during the preceding 3 years indicating the presence of cervical or vaginal cancer or other abnormality. Note: Medicare has added HCPCS code G0101 for cervical or vaginal cancer screening; pelvic and clinical breast examination.
- **Colorectal cancer screening** - Medicare has added screening benefits for the following tests:
 - (1) Screening fecal-occult blood tests are covered once every 12 months for patients who are 50 years or older. Note: Medicare has added HCPCS code G0107 for screening fecal-occult blood tests.
 - (2) Screening flexible sigmoidoscopy is covered once every 48 months for patients who are 50 years or older. Note: Medicare has added HCPCS code G0104 for screening flexible sigmoidoscopy.

If during the course of the screening flexible sigmoidoscopy a lesion or growth is biopsied or removed, the appropriate CPT code should be used (45331, 45333, etc.).
 - (3) Screening colonoscopy is covered once every 24 months for patients who are at high risk for colorectal cancer. High risk has been defined as a person who because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's disease, or ulcerative colitis), the presence of any appropriate gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer. Note: Medicare has added HCPCS code G0105 for screening colonoscopy.

If during the course of the screening colonoscopy a lesion or growth is biopsied or removed, the appropriate CPT code should be used (45380, 45383, etc.).
 - (4) A screening barium enema may be substituted for either a screening flexible sigmoidoscopy or a screening colonoscopy if the patient's physician determines it will be as effective. Medicare will not pay for both a screening barium enema and a screening flexible sigmoidoscopy during the same 48 month period, nor will they pay for both a screening barium enema and a screening colonoscopy for a high risk patient during the same 24 month period. Note: Medicare has added two HCPCS codes, G0106 for screening barium enema, alternative to G0104 screening sigmoidoscopy, and G0120 for screening barium enema, alternative to G0105 screening colonoscopy.
 - (5) Two other HCPCS codes have been added for colorectal screening services which are not covered: G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk, and G0122 - Colorectal cancer screening; barium enema (when used in addition to, not as a substitute). These services are considered "screening" and not covered by Medicare, the patient can be billed.
- **Requirements for furnishing diagnostic information** - Expanded to include services ordered by the physician from other entities, e.g., independent clinical lab. Physicians are required to provide the outside entity with the patient's diagnosis at the time the service is ordered.

- **Physician supervision of diagnostic tests** - Diagnostic procedures payable under the physician fee schedule must be furnished under a specified level of physician supervision; i.e., general, direct or personal supervision. HCFA has reviewed all diagnostic testing and matched what they feel is the appropriate level of physician supervision to each. This information was published in the final rules and regulations on October 31, 1997. This information should be published in a future *Medicare B News* bulletin, if you have questions in the meantime you can contact CMS.
- **Private contracting between beneficiary and physician** - The Balanced Budget Act allows physicians to enter into a private contract with a Medicare beneficiary for health services provided specific conditions are met. **And**, provided the physician is willing to forgo receiving any reimbursement from Medicare for other patients for a period of two years.
It is extremely important for physicians to fully understand the ramifications of "taking advantage" of the private contracting provision as it currently stands. A physician who "opts out" by signing a private contract with a Medicare beneficiary cannot receive **any** money from the Medicare program for a period of two years. This includes payments received not only from the fee-for-service program, but from any Medicare HMO plan as well.
Please note, the private contracting provision in no way affects a physician's ability to bill the patient for coinsurance and deductible amounts, charges for services not a benefit of Medicare, or charges for services that Medicare considers to be "not reasonable and necessary" (providing the physician has had the patient sign a waiver of liability form). These are all charges that the physician has always been able to collect from the patient and still can.
- **New E & M documentation guidelines** - Medicare carriers will not begin using these new guidelines for reviewing physicians' documentation until July 1, 1998 (dates of service). Physicians have been given a six month extension to learn the new documentation requirements.

1998 Medicare Coding Changes

With the new year, Medicare (and most other insurance carriers) will be requiring that billings be submitted using the new and revised codes found in the *1998 ICD-9-CM* and the *CPT '98*. For this reason, it is important that you have the most current edition of these books in your office. In addition, make a note of the HCPCS additions and deletions which were published in the December 1997 edition of the Medicare bulletin.

CPT '98 Changes:

In general you will have a 90 day grace period for implementing the changes into your billing. (Specifically, Medicare will allow you to bill with old codes for dates of service 1/1/98 through 3/31/98 as long as the claims are received prior to 4/1/98.) The following is a **summary** of some of the over 400 CPT updates. Be sure to review the codes used in your office to verify whether or not there are other changes you need to incorporate into your billing.

- **Evaluation and Management services**
99234, 99235 & 99236 - New category of codes added for reporting observation or inpatient care services provided to a patient who is admitted and discharged on the same date of service.
99315 & 99316 - New codes added for nursing facility discharge day management.
99374 - 99380 - The Care Plan Oversight Services section was revised to provide separate codes for patients in home health, hospice and nursing facility care. By making these changes, the HCPCS codes added by Medicare in 1997 are no longer necessary, codes G0064 - G0066 have been deleted. Note: Medicare does not pay for care plan oversight services for nursing home or skilled nursing facility patients.

(Continued next page)

1998 Medicare Coding Changes (continued)

- **Integumentary**

11055 - 11057 - Paring and curettement services have been separated.

17000 - 17250 - Extensive revisions have been made to the lesion destruction section to streamline reporting. By making these changes, the HCPCS codes added by Medicare in 1997 are no longer necessary, codes G0051 - G0053 have been deleted.

- **Respiratory**

31090 - Sinusotomy was clarified to indicate it is a unilateral procedure.

- **Laparoscopy/Hysteroscopy**

56310 - 56349 - Additional codes were added to this section to describe other surgical procedures performed using this approach.

- **Radiology**

76075 - 76078 - The CPT coding for bone mineral density studies has been revised.

By making these changes, the HCPCS codes G0062 and G0063 which were added because of Medicare's restricted coverage for these tests, are no longer necessary. They have been deleted.

- **Pathology and Laboratory**

80002 - 80019 - The CPT codes for automated panels have been deleted. Additions and revisions have been made to the Organ or Disease Oriented Panels (80049-80092) and these are to be used in place of codes 80002-80019, if appropriate. All of the individual tests listed under the panel code must be performed in order to use that code. If not, the individual CPT codes for each test should be reported. If a "customized" panel includes other tests in addition to those defined in the CPT Panel, the additional tests are reported separately under the individual CPT codes. Medicare has also deleted HCPCS codes G0058-G0060.

87260 - 87299 - The infectious agent/antigen testing codes have been expanded to include codes for the specific infectious agent and technique.

88141 - 88152 - Additional cytopathology codes were added to distinguish between physician and technician work.

- **Psychiatry**

90804 - 90829 - Extensive revisions have been made to the psychotherapy section to categorize the services by site, category of psychotherapy, as well as whether or not E & M services were rendered during the visit. By making these changes, the HCPCS codes added by Medicare in 1997 are no longer necessary, codes G0071 - G0094 have been deleted.

- **Physical Medicine and Rehabilitation**

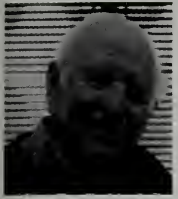
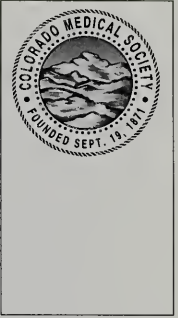
97001 - 97004 - Four new codes were added for physical therapy and occupational therapy evaluations.

- **Conscious Sedation**

99141 - 99142 - Two new codes were added to describe conscious sedation by physicians other than anesthesiologists.

ICD-9 Changes: You must begin using the new ICD-9 codes effective 1/1/98 for Medicare. If you do not, your claims will be rejected as unprocessable.

If you have any questions concerning coding or Medicare, please contact Marilyn Rissmiller in the CMS Health Care Financing Department at 779-5455 or 1-800-654-5653, ext. 2428.



by John L. Lightburn, MD
Historian, Colorado Medical Society

One hundred years ago at CMS

In 1893, the devaluation of silver and a devastating drought had left the economies of Denver and Colorado in shambles. By 1898, the city was recovering. Though the silver industry had collapsed, there was still "gold in them thar hills". The economy was also aided by the influx of hundreds of tuberculosis patients. In spite of the improved economy, there was ferment and discontent throughout the land as Joseph Pulitzer, William Randolph Hearst and Frederick G. Bonfils stirred up the populace with demands for war with Spain on behalf of the oppressed Cuban rebels. President William McKinley, a kind and gentle man, wanted no part of a war and was earnestly negotiating with the Spanish government. But a belligerent Congress and aroused citizenry prevailed and the Spanish American war became a part of our history.

Members of the Colorado Medical Society (CMS), however, had more pressing concerns than the poor Cuban rebels. A year earlier, they had sent Dr. L. E. Lemen to the annual meeting of the American Medical Association in Philadelphia to persuade the delegates to choose Denver as the site for their next annual meeting. Lemen, a former mining camp doctor, was a large and imposing, one might say even awesome figure of a man and was successful in his quest. So for twelve months the physicians and staff of the CMS had been anxiously preparing to host the 1898 annual meeting. The local committee on arrangements was chaired by Dr. John W. Graham, with Dr. S. W. Fisk, vice-

chairman; Dr. J. T. Eskridge, treasurer; and Dr. W. A. Jayne, secretary. There were approximately fifty committee members, all of whom had spent many hours working and planning for the meeting. Chairman Graham worked full time, and for twelve months devoted little time to his practice. Their work bore fruit. The meeting turned out to be the most successful in the AMA history. And it was an important event in Denver in its brief forty year history. It was a grand meeting.



George M. Sternberg, MD, LLD
Surgeon General U. S. A.
President of the AMA

The brand new Brown Palace Hotel was the site of many receptions, meetings and banquets. Across

Broadway was the new and elegant Broadway Theatre where the general meetings were held. Nearby were five large centrally located churches where the section meetings were held. There were twelve section meetings representing Medicine, Pediatrics, Therapeutics and Materia Medica, Dermatology, Surgery, Obstetrics and Gynecology, Neurology, Ophthalmology, Throat and Nose, Physiology and Dietetics, State Medicine and Stomatology.

Special trains filled with physicians and their families from Boston, New York, Cincinnati, Chicago, Louisville, St. Louis and the south were met at the Union Station by a friendly reception committee promising a wonderful time and sunny weather (it rained the first four days). Indeed, every train coming into the station was met by a representative of the society because delegates were arriving from all over the United States. By Tuesday, June 7, 1500 physicians with 500 family members had been greeted by the CMS reception committee.

Three days before the AMA meeting opened, there were meetings of ancillary societies such as the American Academy of Medicine, the Intermountain Medical Society, the Association of Medical Colleges, the Society of Medical Publishers, and various other related organizations. Most of the meetings were associated with banquets which were held at the Brown Palace, the Oxford or the Windsor Hotels.

On Tuesday morning, Dr. Joseph M. Mathews of Louisville, first vice-president, presided over the opening

(Continued next page)

ARCHIVES (Continued)

general session. A large audience filled the Broadway Theatre and seemed excited and enthusiastic. After long and somewhat tedious welcoming speeches by the Governor and the Mayor, Dr. George M. Sternberg, MD, LLD, Surgeon General of the U. S. Army and president of the AMA, was scheduled to give his keynote address. A picture of Sternberg had appeared in the January issue of the *Colorado Medical Journal*. He was an imposing figure of a man, resplendent in his full dress uniform with a chest full of medals. His address had been eagerly anticipated. But he had been detained by urgent problems associated with the recent war with Spain and had sent a copy of his speech to be read by a Colonel Woodhull. The *Journal* reported that "This address was entirely too long and dampened the ardor of the Convention materially".

Happily, the ardor was revived at Wednesday's general meeting when Dr. J. B. Murphy of Chicago presented his paper on the "Cure of Consumption by Compression of the Lung". One reviewer wrote "This was, indeed, a very interesting feature of the meeting, and one calculated to elicit immediate and universal attention. Dr. Murphy's claim that he had and could cure pulmonary tuberculosis by compressing the lung through the introduction of nitrogen into the chest cavity in such quantity as to give the lung tissue complete rest for a few weeks, was a startling proposition and created great enthusiasm". With tuberculosis being a major cause of death and disability, this new intervention was a welcome discovery. It was an important part of our armamentarium until the advent of antibiotics.

One of the most important achievements at the meeting was adoption of the resolution barring from membership in the AMA all physicians on the teaching staff of any medical school that did not conform to the requirements of the Association of American Medical

Colleges. The effect of this resolution was to force all medical schools to



Dr. John W. Graham, MD, of Denver, Chairman, CMS Committee of Arrangements for the 1898 AMA meeting.

adopt a four year curriculum. This was an early step and preceded the Flexner Report by several years.

The Section Meetings

The crowded (probably overcrowded) programs of the section meetings provides us with an interesting insight into medicine practiced 100 years ago. The number of papers scheduled in one section (Neurology) was 89 (more than four papers each hour!), and the total for all sections was over 500 papers. Following is a sampling of some of the papers as reported in the *Colorado Medical Journal*.

The surgery section was the largest and best attended. Over 350 registered for the sessions in the auditorium of the Central Presbyterian Church. Among the list of participants were such well known names as Crile, Keen, Bevan, Murphy, Mayo, Ochsner and Kelly. Bevan gave a scholarly review of the anatomy of the bile tracts. Mayo and Keen talked about stomach surgery with Keen describing a new technique of pylorotomy. Commor discussed the indications of total gastrectomy. LaPlace showed a new anastomosing forceps for the small

intestines, later demonstrating its use on a dog at the Denver Medical College. Keen described the "Closure of the Sacral End of the Gut after Resection of the Rectum for Cancer". There was a long session on appendicitis. Keen's position was that one does not operate simply with a diagnosis of appendicitis alone, while Murphy of Chicago advocated surgery as soon as possible after the diagnosis is made. Other papers were on congenital dislocation of the hip, surgical treatment of tubercular peritonitis, hypertrophied prostate in old men, the surgical management of acute aneurysm, and wounds of the popliteal artery. Dr. Reed of Rock Springs, Wyoming, gave a "thoughtful and valuable" paper on "Post-operative Insanity". Harris of Chicago showed his new instrument for drawing separately the urine from each kidney; he later demonstrated the use of the instrument in a clinic at the county hospital.

For demonstration of surgical procedures, the section went to the new wing of the county hospital where the County Commissioners had converted the upper sunroom into a surgical amphitheater seating 200 observers. In this setting, Keen removed the upper jaw of a little girl with osteosarcoma. Rodman demonstrated the familiar Bassini operation for the radical cure of inguinal hernia. Ridlon did a forcible reduction of the Kyphos of a lumbar Pot's disease. There were other "interesting gynecological operations by Goffe, Kelly and Price. It was later reported that all the patients made uneventful recoveries. It is amazing that such was the level of surgery 100 years ago!

The neurological section met in the basement of the Congregational Church and had over 80 papers presented with an interesting symposium on brain tumors. A paper which asked the question, "Is Pelvic Disease a Cause of Nervous and Mental Affliction?" was read with a gynecologist taking part in the discussion.

(Continued on following page)

ARCHIVES (Continued)

The pediatric section, which met in the basement of Trinity Methodist-Episcopal Church was well attended and usually had fifteen or more female physicians in attendance. One day was devoted to tuberculosis in children. Dr. Louis Fischer's paper insisted that the only cure was continuous out-of-door life. Denver physicians stated that all Colorado children were immune to the disease. In a paper by Dr. E. F. Lawrence of Columbus, Ohio, it was pointed out that tuberculosis peritonitis usually occurred in girls implicating the genital tract as the source of the infection when no primary focus could be found.

And Dr. John Ridlon described a method of forcible straightening of the spine in tubercular kyphosis. The next day, there was a lively discussion of diphtheria and the use of adequate amounts of antitoxin. It was agreed that a physician who failed to administer the antitoxin early in the disease was guilty of criminal negligence.

The Denver Critique, a Homeopathic newsletter, reported the following about the Stomatology section: "Stomatology, in place of dentistry, is now the proper thing, according to a resolution of the American Medical Association at the Denver meeting. You should no longer say 'my dentist', but 'my stomatologist'. A little nauseating at first, but you'll soon get used to it".

Dr. Melville Black reported the following about the ophthalmological section: "The papers were of an unusually high order and were most cordially torn to pieces during the discussion..... The conservative element were in the majority, as it should be..... The banquet gave evidence of being exceedingly dry. To obviate this, our convivial friend Dr. Rivers made a detour among the oculists of Denver and raised a fund whereby the foreseen drawback was obviated.... The ophthalmological section was a great success."

The Exhibit Hall

The hall accommodated a large number of exhibits. Park, Davis & Co. showed a number of rare bacteria, some culture media and some various serums, quite innovative at that time. Fairchild Brothers has a "highly creditable exhibit" of their famous 'Essence of Pepsin, Pancreatin' and other digestive ferments. The McIntosh Battery Co. displayed their Topler-Holtz static machine which gave a 15 inch spark which was "Marvelous". They also displayed electrodes and batteries for use in electro-therapeutics. E. Fougere exhibited and distributed samples of Vin Noury Iodotane which caused considerable smacking of lips among the samplers. Upjohn Pill and Granule Company had an exhibit of "friable" pills. The Antiphlogistine Co. had a "tasty" display. And finally, Lippincott & Co. had a fine book display that featured Mills' new work on *Nervous Diseases*.

In addition to the serious work of the meeting, there were good times planned by the entertainment committee. Each section had a banquet on Tuesday night. There was a grand reception at the Brown Palace on Wednesday night. There were tours of the city in trolley cars, a band concert in City Park and a tour of a smelter.

On Friday, an opportunity to study climatology was provided in an excursion trip up Clear Creek Canyon to Silver Plume, 9,200 feet above sea level. Over 1,700 members and members of their families were accommodated in seven trains on the narrow gauge railroad, given a lunch at Idaho Springs of "full western quantity and that would rate of first quality in any eastern city, and treated to some of the grandest mountain scenery in the world" More spectacular scenery was yet to be experienced by those who took the next days excursion trains to Colorado Springs where they enjoyed the Garden of the Gods and a ride up the cog railroad to the summit of Pikes Peak. After being wined and dined in Colorado Springs, a sizable contingent continued their travels on the Colorado and Midland Railway over Ute Pass, South Park and Hagerman Pass to Glenwood Springs. The CMS had negotiated a fare of \$5.00 for the trip. When all the members had arrived back home, many wrote back letters of gratitude for the wonderful time they had in Denver, Colorado Springs and Glenwood Springs.

Two months later Drs. Graham and Jayne were honored at a dinner at the University Club for their work in making the meeting such an outstanding success

More about the Spanish Flu

Since the article on the influenza pandemic of 1918 (*Colorado Medicine*, Sep. '97 p. 340-342), the September 29, 1997 issue of the *New Yorker* magazine had an article entitled "The Dead Zone" which describes the current efforts to find and identify the deadly virus which caused that epidemic.

Although the *New Yorker* is not the customary source of medical information, author Malcolm Gladwell has written a fascinating article about the efforts of Professor Kirsty Duncan, medi-

cal geographer and climatologist at the University of Windsor in Toronto, to find the virus in bodies of victims of the flu who had been buried in the arctic tundra and thereby preserved in a frozen state.

After many months of searching, she learned of seven coal miners in the little town of Longyearbyen, far north of the Arctic Circle who had died of the flu in 1918. She has organized a multidisciplinary team to go to that far-off Norwegian village to find the elusive but deadly virus.

John Lightburn, MD

Colorado Medical Society

1998 Interim Meeting

Denver Marriott Southeast
(I-25 @ Hampden Avenue)

Schedule

Friday, March 13, 1998

8:00 a.m.- 5:00 p.m.	Caring for Colorado's Underserved Conference
12:00 N- 1:00 p.m.	Lunch - Conference
1:00 p.m.- 2:00 p.m.	Finance Committee
2:00 p.m.- 5:00 p.m.	Board of Directors
5:00 p.m.- 6:00 p.m.	Registration
5:15 p.m.- 5:45 p.m.	Cocktails - Caring for Colorado's Underserved
5:45 p.m.- 7:45 p.m.	Dinner-Caring for Colorado's Underserved

Saturday, March 14, 1998

6:30 a.m.- 4:00 p.m.	Registration
7:00 a.m.- 10:00 p.m.	Office open
7:00 a.m. - 8:00 a.m.	Reference Committee Members Breakfast
7:00 a.m.- 8:15 a.m.	AMA Delegation Forum - open to all members
7:30 a.m.- 8:15 a.m.	COMPAC Board
8:00 a.m.- 8:30 a.m.	Credentials Committee
8:30 a.m.- 9:00 a.m.	House of Delegates
9:00 a.m.- 12:00 Noon	General Membership Meeting
12:15 p.m.- 1:45 p.m.	Luncheon
2:00 p.m.- 4:00 p.m.	Reference Committee
3:00 p.m.- 5:00 p.m.	Reference Committee

Sunday, March 15, 1998

6:30 a.m.- 10:30 a.m.	Registration
7:00 a.m.- 12:00 noon	Office open
7:00 a.m.- 8:30 a.m.	Arapahoe caucus
7:00 a.m.- 8:30 a.m.	Aurora-Adams County caucus
7:00 a.m.- 8:30 a.m.	Boulder caucus
7:00 a.m.- 8:30 am	Clear Creek Valley caucus
7:00 a.m.- 8:30 a.m.	Denver caucus
7:00 a.m.- 8:30 a.m.	El Paso caucus
7:00 a.m.- 8:30 a.m.	Larimer/Weld caucus
7:00 a.m.- 8:30 a.m.	Pueblo/Western Slope caucus
8:15 a.m.- 8:30 a.m.	Credentials Committee
8:30 a.m.- 12:00 Noon	House of Delegates



Dr. Malik Hasan, Chairman and CEO of Foundation Health Systems, will address the House of Delegates on Sunday. Dr. Hasan will discuss what he calls the "Fourth Generation of Managed Care," a high-tech approach to delivering more rapid, direct and cost effective patient care in the future. Don't miss it!

**This portion goes
to CMS**

Interim Meeting Registration

1998 Interim Meeting of the Colorado Medical Society, March 14-15, 1998, Denver Marriott Southeast

Name (*Please type or print*) _____

Name of Spouse/Guest (if attending) _____

Component Society _____ Office Phone _____

RESERVATIONS FOR EVENTS AND MEETINGS

(*Reservation deadline is February 27, 1998.* Reservations accepted on a first-come, first-served basis)

	<u>Number Attending</u>	<u>Cost</u>
Friday, March 13, 1998		
8:00 a.m.-5:00 p.m. Caring for Colorado's Underserved Conference	_____	Free
5:45 p.m.-7:30 p.m. Caring for Colorado's Underserved Dinner	_____	Free
SATURDAY, MARCH 14, 1998		
12 :15 pm -1:45 pm Luncheon	_____	Free

HOTEL RESERVATIONS

Please use the hotel information below to make your reservations directly with the Denver Marriott Southeast. **The deadline for room reservations is February 27, 1998.**

MEETING REGISTRATION

Please submit a registration form by February 27, 1998, if you plan to attend this Interim Meeting. We're delighted to receive it by mail, fax, or phone. We can check you in more quickly and efficiently if you've preregistered, in addition to providing more accurate and therefore cost-saving guarantees for our food functions. Thanks!

MESSAGES

The hotel's phone number is 303-758-7000. (You may want to leave this number with someone.) If you need to be contacted, ask the hotel operator to transfer the call to the CMS registration desk or CMS office.

WHAT TO DO

Complete this entire form and return it to Colorado Medical Society, by mail to: PO Box 17550, Denver, CO 80217-0550, by phone to: 303-779-5455 or 1-800-654-5653 or by FAX to: 303-771-8657.

Hotel Reservation Information

Denver Marriott Southeast
Colorado Medical Society
Interim Meeting
March 14-15, 1998

Reservations for the Interim Meeting at the Denver Marriott Southeast must be made by **phone**. Please call **1-800-228-9290** or **303-291-3637**.

Ask for the Denver Marriott Southeast and **request the Colorado Medical Society rate**: single or double - \$72, plus 11.8% lodging tax. **The CMS room block will be held through February 27, 1998.** The Denver Marriott Southeast will guarantee neither space nor the group rate after that date.

Check in time is 3:00 p.m., check out is 12:00 noon. To avoid cancellation fees, reservations must be canceled before 4:00 p.m. on the day of arrival.

The Denver Marriott Southeast is a full-service hotel offering 725 deluxe guest rooms with non-smoking floors available. In addition to the standard amenities, Marriott offers complimentary coffee service in the lobby each morning, data ports in each room as well as a full-size ironing board and iron in each room.

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Careful Antibiotic Use in Colorado

by Steven Lowenstein, MD, MPH,
Chief Medical Officer, CDPHE
Kenneth Gershman, MD, MPH,
Medical Epidemiologist, CDPHE

Part II – Risks and Reasons

“There is no question that physicians prescribe too many antibiotics.”

Mechanisms of Resistance

As pointed out recently in *Time* magazine, “Humanity once had the hubris to think it could control, or even conquer, microbes”. But in fact, as Harold Neu once observed, “bacteria are cleverer than men”. Bacteria are able acquire resistance to antibiotics rather easily, through gene mutations and through the exchange of genetic information among microorganisms.¹ The pneumococcus, for example, contains genes that code for penicillin binding proteins (PBPs). Frequently, and at random, these genes undergo mutations; the altered genes then code for binding proteins that have a diminished affinity for penicillin and related beta lactam antibiotics. Mutations may also affect the beta-lactamase genes, enabling bacteria to produce extended spectrum beta lactamses that confer resistance to multiple antibiotics. Under the selective pressure of frequent antibiotic use, resistant strains multiply rapidly. To make matters worse, mutant PBP genes may be transferred from one bacterium to another, furthering the spread of pneumococci with enhanced antibiotic resistance.

The Risks of Excessive Antibiotic Use

One key risk factor for the emergence of drug-resistant *Streptococcus pneumoniae* (SP) is excessive use of antibiotics in the outpatient setting. Six studies have demonstrated a direct association between recent antibiotic use (one or more courses of antibiotics within two months) and nasopharyngeal colonization with drug-resistant SP.² Colo-

nization is the necessary prerequisite for invasive infection.³ In addition, a number of studies have demonstrated that recent antibiotic use is an independent risk factor for invasive disease (meningitis, bacteremia and pneumonia) caused by penicillin-resistant SP.²

There is no question that physicians prescribe too many antibiotics. According to the 1992 National Ambulatory Medical Care Survey (NAMCS), a statistical sample of records from physicians' offices, 31 percent of all outpatient antibiotic prescriptions were for common colds, upper respiratory infections (URI's), rhinitis or bronchitis.⁴ These conditions are almost always caused by viruses and rarely warrant antibiotics. An additional 24 percent of antibiotic prescriptions were for pharyngitis or sinusitis, conditions that only sometimes warrant antibiotics. In a subsequent analysis of the 1992 NAMCS data, Dr. Ralph Gonzales, a University of Colorado medical school faculty member, found that 51 percent of adult patients diagnosed with common colds, 52 percent of patients with URIs and 66 percent of patients with bronchitis were treated with antibiotics.⁵ According to two recent estimates, unwarranted antibiotics account for 23-26 percent of the total medical expenditures for uncomplicated URIs.^{6,7}

Reasons for Excessive Antibiotic Use

Why are antibiotics over-prescribed for conditions in which they are ineffective? Consumers and providers are both at-fault. Physicians participating in Centers for Disease

Next month look for tips on using antibiotics in your clinical practice.

Control (CDC) focus groups have stated that maintaining patient satisfaction, time pressures and diagnostic uncertainty lead to unnecessary use of antibiotics (CDC, unpublished data). Reliance on antibiotics to "prophylax" against later bacterial superinfection, administrative barriers to effective follow-up appointments, free antibiotic samples and advertising aimed at providers and consumers may also contribute to unwarranted antibiotic use.

Surveys indicate that many patients and parents have misconceptions about which illnesses warrant antibiotic treatment. In one survey of 961 adults, 79 percent believed that antibiotics are effective in cases of a cold with a colored nasal discharge.⁸ Another study indicated that parents frequently request antibiotics when the physician believes they are unnecessary, and that, "occasionally," the physicians go along.⁹ Physicians often equate patient satisfaction with a prescription for an antibiotics. However, one recent survey found that patient satisfaction was not correlated with receipt of an antibiotic prescription; rather, satisfaction depended upon a careful explanation of a patient's symptoms, diagnosis and expected course of recovery.¹⁰

The Colorado Task Force On Careful Antibiotic Use

Unless we curtail our use of antibiotics, we face the prospect of higher costs, increased morbidity and higher rates of death from common bacterial infections. However, there is reason to believe that using antibiotics more judiciously can slow the emergence of resistant bacteria. Studies in Finland and in Iceland have suggested that intensive medical and public information campaigns can lead to measurable reductions in antibiotic prescribing and in the prevalence of antibiotic-resistant bacteria in the population.^{11,12} To call attention to drug-resistant bacteria, the CDC has published several new guides for patients and providers that emphasize the judicious use of antibiotics.

The Colorado Department of Public Health and Environment

(CDPHE) has also formed a task force to promote careful antibiotic use in Colorado. The Task Force includes physicians from several medical disciplines, as well as representatives from nursing, managed care, pharmacy, the media, the pharmaceutical industry and the Colorado Legislature. The Task Force has developed a brochure for patients and an information sheet for physicians; both emphasize careful diagnosis of upper respiratory syndromes, deferring antibiotics, and adopting a watch and wait approach (along with symptomatic relief) for common colds, pharyngitis, purulent rhinitis and bronchitis. The Task Force has also coordinated with the CDPHE's Survey Research Unit to conduct a statewide telephone survey to measure citizens' knowledge about coughs and colds and their attitudes toward antibiotics. Through this campaign the Task Force also hopes to persuade managed care leaders to distribute information about the risks and benefits of antibiotics to their plan members and to develop educational materials and individual prescribing practice profiles for providers. Another key strategy is the aggressive use of influenza and pneumococcal vaccines for patients in high-risk groups. According to CDPHE's Behavioral Risk Factor Surveillance System, only 66 percent of Coloradans age 65 and over are immunized against influenza each year, and just 45 percent have ever received the pneumococcal vaccination.

It is time to change the way we prescribe antibiotics for coughs, colds and other upper respiratory infections. Adopting an approach of careful antibiotic use may benefit patients and the community-at-large and prevent or postpone the day we will have to practice in the post-antibiotic era. For more information on Colorado's Task Force to Promote Careful Antibiotic Use contact Dr. Kenneth Gershman at the Colorado Department of Public Health & Environment (phone: 303-692-2657 or e-mail: ken.gershman@state.co.us).

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Colorado Physician Network, Inc.



by David M. Martz, MD
President CPN

Fine tuning

There have been several key developments that have occurred in recent weeks that merit your immediate attention.

First of all, we are delighted to report dramatic new growth in our physician panels on the Front Range. Nearly all of the physicians in the Loveland and Greeley area are now CPN members, and the Pueblo panel is nearing completion.

Secondly, contracts with several important hospitals in the Arkansas Valley region that have been ongoing for many months are nearing closure as this is written and expected to be finalized by the time you read it.

Thirdly, a new Pharmacy Benefit package has been adopted that provides a three-tier approach to prescriptions: co-pay increases slightly as patients and their physicians choose from generic to preferred brand name to non-preferred brand name (eg., \$10-\$15-\$25). This allows appropriate patient and physician interactive decision making without managed care blockade, and avoids the frustrations created by a closed formulary.

Fourthly, we are moving forward rapidly with the development of EPIC, our consortium with RMHMO, COPIC, and MMA. Details will be forthcoming in the next few weeks.

And finally, we are anticipating new intensity in our marketing strategy.

RMHMO has expanded its marketing, UM, and Provider Relations staff significantly in recent weeks, and we are now expecting implementation of an energetic and focused outreach in the immediate future.

It always takes longer than expected to build a house, let alone a managed care program. We are eager to see the finished product, but the essential inner structure must be well developed first. Stay tuned!

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BOULDER – Excellent opportunity for Board Certified MD in Urgent/Family/Occupational care. Reply to Medical Director, Meadows Medical Center, P.C., 4800 Baseline, D-106, Boulder, CO 80303-2643. (303) 499-4800. 04/1097

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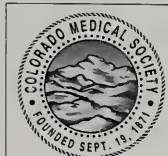
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Colorado Medical Society



RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

An invitation to the AMA from the CMS, circa 1898

THE COLORADO MEDICAL JOURNAL.

*A Scientific Medical Journal, Published in the Interest of the Profession of Colorado and Adjoining States. A Truly Local Journal.
A Journal of Science, of News, and of Medical Lore.*

VOL. IV.

DENVER, COLO., MAY, 1898.

NO. 5.



DENVER AND THE WEST GREETES THE AMERICAN MEDICAL ASSOCIATION.

MAY THE HOURS SEEM SECONDS AND MAY COLORADO'S OZONE
GIVE TO ITS MEMBERS A NEW LEASE ON LIFE—MAY
COLORADO'S SUN, SHINE FOR YOU AS
IT DOES FOR US.

NEWS—NOTES—COMMITTEES AND SOUVENIR ILLUSTRATIONS.

I couldn't help myself! I started reading Dr. Lightburn's piece this month and suddenly this jumped out at me... a 100-year-old picture of the 1600 block of Glenarm Place in downtown Denver.

The church is identified as the First Baptist Church. That was gone by the '40s. The building at the right of this photo is the Denver Club Building (at 17th and Glenarm), always an imposing structure and

one which held much mystery to the likes of me. I never aspired to being a member because this was the domain of the rich and famous (as rich and as famous as you could get in Denver during its first 80-90 years). I often wondered what stories the building could tell if only it could speak. When the building was razed to make way for the Majestic Savings and a new Denver Club, it was a sad occasion. To me, that marked a substantial change in the character of Denver; it was a harbinger of the many characterless glass and aluminum buildings to follow.

In the 1930 through 1960 era there was a rather small group of people who held the reins of power in Denver. Remember, Denver was an overgrown "cow town" until Mayor Federico Peña arrived with his "Imagine a Great City" slogan. Some of those I remember were Mayor Speer; Billy McNichols (Mayor Bill's father); Mayor Ben Stapleton, Sr. and his right-hand man, "Crowbar" Williams; Mayor Quigg Newton; state legislator and Mayor's Aide Ben Bezoff; Bill McNichols, Administrative Aide to his brother, Governor Steve McNichols; Denver City Attorney Max Zall; Temple Buell; Lawrence C. Phipps, Sr.; Eugene Dines; Frederick Bonfils; Harry Tamman; Carl Sandell (the 7 ft. tall doorman at Daniels & Fisher Stores); Bill Zeckendorf; Merchant Marine Captain Mary Converse, just to name a few.

Anyway, I had to print this *Colorado Medical Journal* page. And I don't think the AMA has been back.

Be sure to read Dr. Lightburn's "ARCHIVES" in this issue.



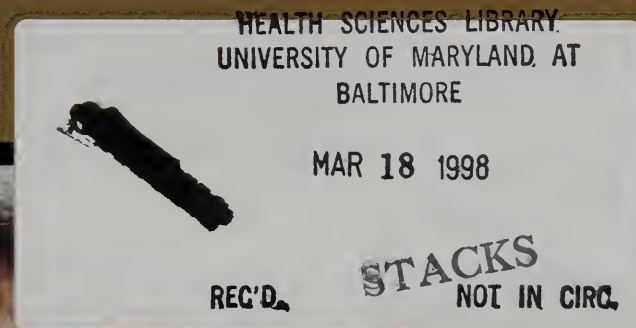
COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

January, 1998

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Volume 95, Number 2



Mary Lou DeMund
May 17, 1939 - January 20, 1998

This Issue:

Professionalism: what is it? by Gary D. VanderArk	page 41
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Outcomes from the Clinician's Perspective by Byron D. Jones, MD	page 46
Archives: Connecticut Yankee Doctor by John L. Lightburn, MD	page 49

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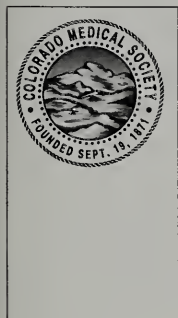
January, 1998

Volume 95, Number 1



Cover Story

Mary DeMund's passing was mourned by many people, but no more than by the hundreds of students and residents whom she helped through 30 years of service. (Memorial Page 42)



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*Gary D. VanderArk, MD
President, Colorado Medical Society*

42 A memorial to Mary DeMund, the Director of the Denver Medical Library who died on January 20, 1998, after 30 years service and friendship to physicians, medical students, residents, all persons who needed the rich resource of the Denver Medical Library.

44 1998 Leadership Conference at Sonnenalp Lodge. The CMS President-elect will be hosting the Leadership Conference this year, which promises an interesting and worthwhile program. The author says "There are changes coming."

*by W. George Shanks, MD
President-elect
Colorado Medical Society*

46 Outcomes from the clinician's perspective. This is another OF the follow-up articles that have been done concerning Accountability in medical practice.. These articles are authored by those who participated in last year's Leadership Conference. The author is

*Byron D. Jones, MD
Denver Spine and Rehabilitation Clinic*

48 Careful antibiotic use in Colorado. Part III and final part. Information and practice tips.

*by Steven Lowenstein, MD, MPH,
Chief Medical Officer, CDPHE
Kenneth Gershman, MD, MPH,
Medical Epidemiologist, CDPHE*



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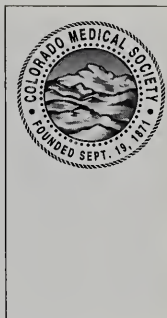
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Gary D. VanderArk, MD
President, 1997-1998

Professionalism

Not long ago, I developed a bad tire on my car. After pumping it up several times and watching it go soft again, I visited my local tire store. The proprietor examined the tire and then looked at all of the tires on my car, declaring that I really needed four new ones. I agreed but acknowledged a problem of time because I only had one hour before an appointment in the operating room of a hospital several miles away. He assured me that everything could be finished in time and assigned a worker to immediately begin the job. This story has a happy ending. They did it. The tire shop completed the work in forty minutes. I complimented the manager on a job well done and he replied, "We provide good service because we're professionals."

Recently, Larry Walker was named the most valuable player in the National League. Now I realize that Larry Walker is a professional ball player as opposed to an amateur, but in writing about Larry's award the newspaper described him as the "consummate professional."

Not too long ago, I visited the Netherlands in search of my ancestral roots. One of the cities on our itinerary was Amsterdam, and one of the two places I wanted to see was the Oude Kirk (Old Church). We were warned that it was not in a very nice part of town. Indeed, the Oude Kirk is in the middle of the red light district and the streets (and windows) were filled with "ladies of the night" plying their profession.

All of this got me thinking about our profession and what professionalism means to today's society. If you want a definition, don't bother getting out your Webster's or any dictionary because it's not going to help. For a definition of a profession you need history books or you need to consult a sociologist.

Traditionally, society has accepted three learned professions: law, medicine and religion. Use of the term "profession," however, probably only goes back to the seventeenth century and it really took sociology to become developed as a social science before definition was clarified. So professionalism is a fairly recent concept of the twentieth century.

I think the meaning of a profession can be distilled into three main tenets:

- it is special training and a unique body of knowledge;
- it is a calling to serve others; and
- it is dedication to self-regulation.

Medicine certainly qualifies as a profession on the basis of educational requirements. Four year of college, four years of medical school, four or more years of post-graduate training, combined with years of continuing medical education single us out as a learned profession. We also have training in a particular set of principles. Our profession has an ethical base. You cannot graduate from medical school without taking the Hippocratic oath. As new procedures and ethical dilemmas arise, we lead the debate to clarify their place in our society.

"... the streets (and windows) were filled with 'ladies of the night' plying their profession."

Medicine is a vocation or calling that provides service to others. We serve people in need that we call patients (as opposed to clients or customers). As physicians we develop a very special relationship with the people we serve.

Medicine as a profession must determine its standards. We must be accountable to our patients and to medicine as a whole. Physicians must regulate themselves.

There it is. You have heard my definition.

Next month in **Colorado Medicine** I will look at my perception of how we are doing as a profession and what the Colorado Medical Society is doing about it.



*Mary Lou DeMund
May 17, 1939 - January 20, 1998*

IN COMMEMORATION

Excerpts from comments of friends in a memorial service at Presbyterian/St. Luke's Hospital on Friday, January 23, 1998

Mary DeMund

I've misplaced a friend,
I think.

I know she's hereabout
Somewhere,
Puttering
In this library's recesses,
Soon to burst out,
All her eyes staring,
Daring me to disagree
When she says

"We've got a computer
That can find things!
Isn't that wonderful?"

Oh, Mary, it was you
Who was wonderful.

We're here--
We've stopped,
To speak to you once more
And wonder how
Someone so real
Could vanish
In the middle
Of our sentence.

*Fred Platt, MD
January 23, 1998*

With the passing of Mary DeMund on January 20, 1998, also passed a long tradition of a librarian who was more than a librarian, a friend who was more than a friend, and a pillar of support to the medical community of Denver.

In her 30 years service to the Denver Medical Society and the Denver Medical Library, Mary was a rich resource of information of any type for any physician who needed help. Pleasant beyond description and willing beyond belief, she served as wise counsel to all, be they interns, residents, paraprofessionals or long-standing practitioners. She served all comers with impartial dedication. Mary will be sorely missed.

*W. Gerald Rainer, MD
Past President
Denver and Colorado Medical Societies*

Many physicians in the greater Denver area were shocked and deeply saddened by the sudden death of Mary DeMund. Mary was so much a part of the medical scene that her name was synonymous with that of the Denver Medical Library.

Among her many talents was her constant, enthusiastic, incredibly efficient dedication to assisting physicians and medical personnel find the information that the library patron needed.

She bridged an era in which library science has shifted from the journal and textbook to the computer and electronic printer. Typical of Mary, she was so alert to the changes in her field that for some of us, the first time we heard terms such as "Modem" and "CD ROM," it was from her while she patiently explained what the library needed to remain current.

One of the many times Mary demonstrated her marvelous organizational skill was during the move of the library, spanning several months, from the original "DML" building at 1601 East 19th Avenue to the basement of the Denver Presbyterian Hospital, and then to its present location in the lobby of the new Columbia-Presbyterian/St. Luke's Medical Center. Throughout this time of upheaval, remarkably, Mary saw to it that the library continued to provide quality service.

In addition to these many attributes, Mary was always a gracious, caring person who had the ability of making most of us immediately comfortable in her presence.

She will be greatly respected, sincerely loved, and sorely missed. We are, indeed, fortunate to have known her

*Giles D. Toll, MD
Mamber, Board of Directors
Denver Medical Library Foundation*

In memory of Mary DeMund

William Faulkner said, and I can repeat this without worrying about being politically correct, because Mary DeMund was not a sexist:

I decline to accept the end of men... I believe that man will not merely endure: he will prevail. He is immortal not because he alone among creatures has an inexhaustible voice but because he has a soul, a spirit capable of compassion and sacrifice and endurance.

I personally refuse to accept the idea that Mary is no more. She lives as vividly in my mind as though I can hear her laughter at this moment. She lives in everything the Denver medical Library has become. She lives in the many people who have been influenced by her care and understanding, in their search for information, knowledge.

It's very interesting: Mary has, for years, been the first thing to pop into my mind when I approached this spot, this hospital, this library. It's as though it were her own space, and when I passed to within a certain distance of her office and the Library, I felt those vibrations.

With all the changes around us, I took comfort in the fact that Mary was a constant; I could talk to her about anything... and enjoy it. Her sense of humor was priceless; at least she and I seemed to think a lot alike. I attributed it to the fact that our birth days (not birth dates) were just one day apart. One thing for sure: I'll never pass another of my birthdays without thinking of Mary.

During Superbowl weekend she may well have had some thoughts as a kindred spirit for that Wisconsin football team, but her heart was firmly behind and in Broncoland; however, sports is one thing Mary and I never talked about. I didn't meet Mary until some time in the '70s when I would be working on a story and I would call or go to the library and talk with her. She often turned the conversation into interviewing me because she was so interested in everything, particularly what was happening out there on the street. We talked a lot. She and I always found wonderful, historical things to discuss. I'll never forget her. She made such a difference in so many things. . . to so many people.

As 18th century essayist William Hazlitt said,

*Man is the only animal that laughs and weeps;
for he is the only animal that is struck
with the difference between what things are,
and what they ought to be.*

Truly, Mary is a fine example of what things ought to be, and now, as we mourn her leaving, she reminds us of our own frailty and how things really are.

Bill Pierson
Colorado Medical Society

Mary Lou DeMund was born in Beaver Dam, Wisconsin on May 17, 1939. Her parents, Celia and Lester DeMund, also had two other daughters, Phyllis and Beverly. Mary's daughter Susan DeMund, son-in-law Philip Bund and granddaughter Jordan live in Denver.

Mary's early education was in a Catholic school in Beaver Dam. She attended Whitewater College in Wisconsin where she majored in English. Upon graduation, Mary taught English at Beaver Dam High School.

Mary's favorite pastimes were travel, gardening, reading and home redecorating. She loved to look up horoscopes and create a personalized horoscope birthday book for people on their birthdays. Mary was also an avid Denver Bronco fan.

She was a strong, independent woman. Described as a "great mother," she managed to raise her daughter, Susan, on her own and created a loving home.

Mary moved to Denver in 1968 where she took a temporary position working in the Denver Medical Society Library. In five years Mary was promoted to Library Director. She frequently commented on the many transitions the library had experienced in her thirty year experience.

Due to Mary's extreme dedication and commitment to the Denver medical Library, the institution has grown to serve those who seek the knowledge she worked so hard to collect.

Persons wishing to honor her memory may contribute to the **Mary DeMund Memorial Fund** in care of the Denver Medical Library, Columbia-Presbyterian/St. Luke's Medical Center, 1719 E. 19th Avenue, Denver, CO 80218



SPEAK OUT

W. George Shanks, M.D.
1998 President-elect
Colorado Medical Society



1998 Leadership Conference

*"... some of the issues
that we face each day
which make it very
difficult to be a doctor."*

The CMS Leadership Conference, formerly known as the President's Planning Conference, will take place this year at the Sonnenalp Lodge in Vail, Colorado, during the first weekend of May. In keeping with my campaign pledge to "make it easier for a physician to be a physician," I would like to explore some of the issues that we face each day which make it very difficult to be a doctor.

If you have felt hassled in the past, then you should feel totally harassed when the full effects of Medicare's regulations on **Automated Panels** and the **E&M** (Evaluation and Management) **Codes** are fully implemented. Although there is abundant material out there for educational purposes, I seriously doubt that the vast majority of you will be able to comply and keep the FBI from knocking at your door. We need to explore the means to collectively modify these unreasonable intrusions into the practice of medicine, and at the same time, create a strategy to help our members unlucky enough to get caught in the trap.

A second area of interest is the physician's relationship with medical insurance companies. With the emergence of managed care as the primary player, it is high time that we accept this fact and start to evaluate the impact that this has on the delivery of health care.

To this end, I would like to set up the mechanism whereby the Colorado Medical Society would establish criteria for judging the effectiveness of health care plans. This would include the ease with

which the patient can access the system. And further:

- Does the patient have an adequate panel available to select a personal physician?
- Would the referral to specialists be prompt and efficient?
- Is the relationship of the physician and the insurer more in the order of a partnership with a professional, or is it in reality something less?

If we find that there are some managed care organizations that meet our criteria, then I think we should let our patients know of our approval. The contrary should also be applied.

We know what is best for our patients and ourselves. We have been silent too long. Let's get together in May and resolve these and other issues.

There is no doubt in my mind that we can influence the future of medicine in this state, and that the CMS is the ideal vehicle to affect these changes.



by David M. Martz, MD
President CPN

Retreat! Retreat!

Retreat! Retreat! It's time to retreat!! No, not in the bugle call sense of fall back and cover your losses, but rather in the sense of focused strategizing! At the time of this writing, two important retreats which affect Colorado Physician Network (CPN) and its immediate goals have been planned and scheduled.

On Saturday, January 31, Rocky Mountain HMO (RMHMO) will hold its annual Board retreat, and the attendees will be receiving an update on CPN's recent interaction and pending issues before the RMHMO Board of Directors.

Likewise, on February 12, the CPN Board will have a retreat which will be attended by the leadership of RMHMO.

The purpose of these get-togethers is to analyze and clarify the next steps in marketing **Rocky Mountain Physicians Choice** along the Front Range in general, and the Denver Metro area in particular. Completing our physician panels in key areas, establishment of competitive premiums, and specific marketing strategy will dominate the discussions. Your potential role in the marketing efforts will be of particular importance.

We are pleased to note that RMHMO has again shown profitability in the last two quarters of 1997. The HMO war is a brutal one, and we dare not underestimate the importance of fiscal responsibility to our patients, physicians, and organization as we move forward with our commitment to "do managed care right!"

Yes, it's time to retreat, and we hope to do it wisely in the days ahead. I plan on reporting the outcomes of these milestone events in the March issue of **Colorado Medicine**. Stay tuned!!



Malik Hasan, M.D., Chairman and CEO of Foundation Health Systems, will address the House of Delegates on Sunday, March 14, 1998, at the Denver Marriott Southeast, I-25 and Hampden Avenue. Dr. Hasan will discuss what he calls the **"Fourth Generation of Managed Care,"** a high-tech approach to delivering more rapid, direct and cost effective patient care in the future.



Attention Physicians: Did you know?

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CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax®
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

2nd Annual Conference on "Caring for Colorado's Medically Underserved"

Caring for Colorado's Medically Underserved conference will be held on March 13, 1998, at the Denver Marriott Southeast at Interstate 25 and Hampden in Denver. The one day conference again promises to be filled to the brim with outstanding participants and features.

Keynoting the conference will be Jack Lewin, MD, Executive Vice President of the California Medical Association. Dr. Lewin gained high visibility during the Clinton Administration's efforts to reconstruct the U. S. health care delivery system.

Dr. Lewin was also Hawaii's Director of Health from 1986 to 1994, during which time the state mandated employer coverage of health insurance.

Also on the program are a number of presentations, including "Current Opportunities for Change," "Defining and Measuring Community Benefit," and "Evaluating the Impact of Programmatic and Policy Changes: What really happens to care for the medically underserved."

The day's conference will be topped off by an action plan: "Identifying the Direction for Colorado: Where do we go from here?" by Larry Kieft, MD, Clinical Director of the Poudre Valley Prenatal Program.

At the conference banquet on Friday evening, the program will include an address by Reed Tuckson, MD, Group Vice President for Professional Standards of the American Medical Association.

Prior to his current position, Dr. Tuckson was President of the Charles R. Drew University School of Medicine and Science in Los Angeles. The University's mission embraces the concept of educating and preparing physicians and allied health professionals to serve traditionally underserved communities. The Awards Banquet is to give recognition to those people who have made outstanding contributions in the provision of care to the medically underserved.

Contact CMS for information and registration at (303) 779-5455 or 1-800-654-5653, ext. 2404.

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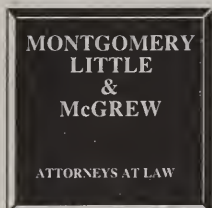
In the March issue of **Colorado Medicine** we continue with the monthly feature called "Accountability," a simple guide to physician accountability, outcomes measurement, methods and analysis.

The March article will be

"Surveillance and Follow-Up of Persons with Traumatic Brain Injury in Colorado"

by Gale Whiteneck, PhD, Richard Hoffman, MD, MPH, C. A. Brooks, MSHA, Barbara Gabella, MSPH

Watch for "ACCOUNTABILITY"
in **Colorado Medicine**.



Med Fax: Medico- Legal News

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Mesa County physicians claim partial victory over the Federal Trade Commission

The Federal Trade Commission (FTC) suit and investigation of the Mesa County Physicians, IPA, Inc. (IPA) is about to be settled. If the settlement agreement is approved by the FTC Commissioners - which is expected by attorneys from both sides - the nearly two year ordeal will end for the IPA.

The key element of the dispute was the size of the IPA. The FTC claimed the large size was anti-competitive, and the physicians maintained the large size allowed better patient care and other community benefits. The proposed consent decree, which has not yet been released to the public or signed by the Commissioners, allows the 190 member organization to continue to function. This is a major aspect of the settlement with the FTC and a victory, of sorts, for the IPA physicians.

The IPA membership consists of approximately 85% of the total local physicians and over 90% of the primary care physicians. In 1974, the predecessor of the IPA started Rocky Mountain HMO (RMHMO) which now sells about 50% of all the medical insurance in Mesa County. In late 1995 or early 1996, someone made a complaint that the IPA was anti-competitive. Although the claim was not disclosed, it apparently alleged that the IPA had harmed some health insurance companies (especially their profits). A lengthy investigation followed, with thousands of pages of documents sent to the FTC, and depositions taken of many of the physicians. This investigation consumed months of work by the physicians, staff, and attorneys for the IPA, with legal bills consuming the assets of the organization.

The FTC first offered the IPA a consent decree late in 1996 that would have required them to stop collectively signing contracts where we were not at-risk and

to remove 70% of the primary care physicians from the IPA, effectively putting the IPA out of business. The complaint further charged the IPA conspired to fix prices and refused to deal with insurers who did not meet their demands. The IPA Board refused to sign the consent decree. The physicians denied the charges and pointed to the 25 year history of the organization that improved health care for the people of Mesa County. At that point, the investigation had cost the IPA about \$250,000.

In January 1997 the IPA sought help from the AMA, RMHMO, CMS, and the Copic Insurance Company. All of these organizations assisted the physicians in some capacity in their dispute with the FTC. The AMA was especially helpful to the physicians. After being informed about the issues, the AMA leadership provided substantial financial support and contact with additional legal counsel for the IPA.

The FTC filed a suit in May of 1997 after the physicians refused to admit to any wrongdoing. The IPA pointed out the integrated network was essential in improving care for the uninsured and poor patients in Mesa County. The physicians in the IPA strongly believed they had done nothing wrong, and their activities had improved the quality of care in Western Colorado. Programs that paid for free vaccinations and allowed Medicaid patients a wide variety of physicians and services helped illustrate their side of the dispute.

The case seemed to be headed to a trial scheduled for January 1998 when the FTC proposed a settlement that the physicians could agree to. The new settlement tells the IPA to disband its contract review committee, and only jointly enter at-risk contracts. The IPA cannot contract collectively on non-risk contracts. But the key demand that the IPA disband into no more than 20-30% of the region's physicians was dropped. The essential destruction of the IPA was stopped, allowing the physicians to declare a major victory. A small organization stood up to the federal government and refused to give in to their demands.

This event has been a costly two-year ordeal for the IPA. The IPA can continue to exist and continue most of the services and functions it was created to do. But it has taken a huge toll on the leadership and physician members of the IPA. Although the IPA expects to get most of the legal costs paid for by its insurance policy, the cost of time and stress on the IPA was tremendous.

There are many important messages learned from this experience. Physicians in towns our size and smaller can form an IPA together, and can have inclusive (but non-exclusive) IPAs where there are sufficient resulting efficiencies in the delivery of health care. Members need to continue to "compete" with their IPA colleagues in contracting (unless at-risk) and

(Continued on following page)

(Mesa-FTC cont. from page 1)

negotiate fees separately. It is permissible to educate your members, but it is not permissible to tell doctors what contracts should or should not be signed. Providing non-fee and non-competitively sensitive information is acceptable. Collective contracting on a non-exclusive basis can be acceptable where the physicians are at risk, or where there is sufficient clinical integration to produce significant efficiencies in the delivery of health care.

There were many other items we learned from this investigation and suit. The FTC does not need to tell you who filed the complaint. A FTC suit is expensive, for both sides. We will never know how much the federal government spent on this case. The IPA spent about \$500,000.

For other physician groups we have some advice:

- 1) Assume a hostile force will read all four minutes in the light most unfavorable to you and your organization. You should be aware that highly detailed minutes could be risky. Some items in our minutes were used against us, even when we decided properly on the action discussed.
- 2) Train yourself and your staff to review your minutes, your public communications and your contracting measures for antitrust problems. Often innocent-appearing facts are used as evidence against you. Wording is everything. Consider having your attorney review sensitive material.

- 3) Secure good entity coverage along with your directors and officers insurance. (We had to threaten to sue our insurance company, but they finally agreed that this was a covered claim.)
- 4) To the FTC, money is the primary motivating factor of all physician behavior.
- 5) Do good works as a group. Our best defense was our work with Medicaid, indigent care, immunization projects, and the Colorado Child Health Plan - all money losers but critical components of community health. Our IPA had people from these organizations eager to testify on our behalf.
- 6) Be clinically integrated. Our IPA strives to improve the quality of medicine that is practiced throughout the community. In the final analysis, this effort probably helped us more than the FTC acknowledged.
- 7) Plan on being investigated and prepare for it. We had always joked that letter from the FTC would mean that we were being effective. I guess we were.

The IPA physicians cannot say enough good things about the AMA. The AMA really went to bat for rural primary care physicians on this case. Before this experience, only 18% of our IPA members were AMA members. Now almost all of them are. If you would like more details, all our documents and the FTC documents are on our web site at

www@ruralhealth.org/mcpipa.

David M. West, M.D.

Roger Shenkel, M.D.

AMA notes at press time

AMA Trustee, John C. Nelson, MD, MPH, participated with the cable TV industry and children's advocacy groups in Washington, D. C. unveiling a guide on the television rating system that will help increase parents' media literacy so their viewing decision can take into account a blend of age and content information. The guide is entitled Tools to Use to Help You Choose: A Family Guide to the TV Rating System and is available free of charge from the cable industry.

The AMA lobbyists report that House Speaker Newt Gingrich (R-GA) has appointed ten members, as follows, to serve on a working group on health care quality: Charlie Norwood (GA); Harris Fawell (IL); Mike Bilirakis (FL); Bill Thomas (CA); Porter Goss (FL); Sue Kelly (NY); Jim McCrery (LA); Deborah Pryce (OH); Jim Talent (MO); and Kay Granger (TX). In addition, Representative Dennis Hastert (IL) will chair the group.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Colorado Society of Osteopathic Medicine

Ski & CME Midwinter Conference

February 22-27, 1998

Keystone Lodge & Resort, Colorado

38 hours AOA Category 1-A, AAFP prescribed course hours; AAPA credits

Contact: Patricia Ellis (303) 322-1752 or 1-800-527-4578

Medical Education Resources, Inc.

Dermatology for the Non-Dermatologist

February 13-15, 1998

Breckenridge, Colorado

11 hours of Category 1 credit

(303) 798-9682 or 1-800-421-3756

American College of Cardiology

5th Annual Echocardiographic Workshop on 2-D

Doppler Echocardiography at Vail

February 23-26, 1998

Vail, Colorado

18 Category 1 AMA

1-800-253-4636, ext. 695

2nd Annual Conference on

"Caring for Colorado's Medically Underserved"

Friday, March 13, 1998

Denver Marriott Southeast (I-25 at Hampden),
Denver, Colorado

(303) 779-5455 or 1-800-654-5653, ext. 2414

American Lung Association

17th Annual Big Sky Pulmonary & Critical Care Medicine Conference

March 25-28, 1998

Big Sky Montana

(406) 442-6556

Fifth Annual Colorado Safety and Injury Prevention Conference

April 29, 30 and May 1

Breckenridge, CO Beaver Run Resort

(303) 861-6628

Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, have them send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include information detailing program sponsor, date, location and phone number for more information.

HELP! HELP! . . . and HELP!

The Colorado Medical Society, Task Force on Youth is seeking additional members to assist with our charge of promoting healthy lifestyles for children and youth. The Task Force continues its work on behalf of comprehensive health education and is expanding the firearm safety education project. Current members are discussing potential new projects and welcome your input. Please contact Suzi Shevell at 303-930-0407 or 1-800-654-5653 for more information.



*Christopher Unrein, DO, Chairman
Council on Legislation*

It is early in the legislative year and the medical society has already achieved one of its goals.

The chiropractic prescribing bill was defeated in committee the week of January 12th. We still have to deal with the pharmacists' proposal to have "dependent prescribing privileges."

With all these non-physician health care providers requesting to be given prescribing authority, it might seem odd to physicians that legislators should even listen to them. Organized medicine contends that to perform the functions of a physician, you need to go to medical school, right? The reason the legislators listen to these other professionals is an obvious one: money.

Employers are looking for ways to reduce health care costs and these other medical professionals are more than willing to step in with the condition that they can do it just as well for less. As physicians, we know this is not true. The other way money is playing into this is through constituency. These other professions are willing to meet with the legislators and contribute funds to election campaigns. Yes, money does get them to listen. Legislators are willing to learn about the issues; however, when given the choice, they will solicit opinions from someone who has been involved in their campaign over someone who has not. In the past, many CMS members have not been willing to contribute to campaigns; as a result, those other professions have had the legislative ear.

All that said, a new opportunity is arising in Colorado politics with

the implementation of term limits and campaign finance restrictions. Many veteran legislators are leaving under mandate. It is a bittersweet experience for medicine. Some of our friends are leaving and some legislators who have not been very sympathetic will also be going. This, coupled with the fact that PACs are being limited in the amount of their contributions, gives grass-roots constituents the opportunity to participate and be heard like never before. Yes, it means you have to contribute to your legislator's campaign, but the act will afford you the opportunity to educate your legislator. Also, remember that campaign contributions need not be solely financial. With the mandatory turnover in the legislature and the limitation on PACs, physicians can educate and influence their legislator on issues just as those other health care professionals have. By getting involved, we can do what we do best: advocate for the well-being of our patients and balance the forces in the political world.

A great opportunity for our members to participate in the legislative process is at the **CMSA Day at the Capitol** on March 2nd at 8:00 am outside the Old Supreme Court chambers.

Here are summaries of the bills that are of significant interest and CMS's position at press time.

SB 036, Requirement for Licensure of Physicians Lawfully Practicing Medicine in Another Jurisdiction

(Wham). CMS supports this proposal, adding language to the Colorado Medical Practice Act requiring persons from out-of-state to

"Organized medicine contends that to perform the functions of a physician, you need to go to medical school; right?"

hold a Colorado license if they practice telemedicine on more than an occasional basis.

SB 075, Governmental Immunity for Certain Health Care Professionals Employed by Public Entities

(Thiebaud). CMS opposes SB 75 which eliminates governmental immunity for physicians and dentists employed by public entities.

HB 1104, Certain Required Automobile Insurance Coverage Amounts

(Viega). CMS opposes this bill which reduces the current mandatory minimum automobile insurance coverages from \$50,000 to \$5,000.

HB 1216, Collaborative Drug Therapy Agreements Between Physicians and Pharmacists

(Paschall). CMS opposes this bill which allows physicians and pharmacists to enter into collaborative drug therapy treatments.

For the very latest on legislative issues and CMS's positions, please refer to the CMS web page (at www.cms.org) under "Heard on the Hill."



Careful Antibiotic Use in Colorado

by Steven Lowenstein, MD, MPH,
Chief Medical Officer, CDPHE
Kenneth Gershman, MD, MPH,
Medical Epidemiologist, CDPHE

Part III – Information and practice tips

Steps you can take to encourage careful antibiotic use.

Resistance and antibiotic use

Streptococcus pneumoniae is the leading cause of community-acquired pneumonia, bacteremia, bacterial meningitis, and otitis media in the United States. Antibiotic-resistant pneumococcus was uncommon in the United States through the 1980s. However, during the 1990s, pneumococcal resistance to penicillin and other antibiotics has become increasingly prevalent.

- In Colorado, 15 percent of invasive pneumococcal isolates were resistant (intermediate or highly resistant) to penicillin in 1996.
- Unnecessary antibiotic use for upper respiratory infections is one of the most important reasons for the spread of antibiotic resistance. Multiple studies have identified recent antibiotic use as an important risk factor for colonization or invasive disease with resistant pneumococci.¹

Practice Tips

Make careful antibiotic use a routine part of your clinical practice.

- **Share the facts** – take the time to explain that most coughs and colds are caused by viruses; that viral infections are not cured by antibiotics; and that secondary bacterial infections are not “prevented” by antibiotics in otherwise healthy persons. Provide educational materials to reinforce this information.
- **Explain to patients and parents that unnecessary antibiotics can be harmful** – Antibiotic use promotes the growth and spread of resistant organisms in them, their family, and the community; and, on occasion, may cause severe allergic reactions, antibiotic-associated colitis, and other side-effects.
- **Encourage active management of the illness** – recommend explicit treatment for cough, congestion, and other symptoms. Explain the normal duration of upper respiratory infections, and counsel the patient or parent to come back if symptoms worsen or persist beyond the expected duration.
- **Encourage immunizations** – pneumococcal vaccine is recommended for persons aged ≥ 65 years and for persons with chronic illness or asplenia. Yearly influenza vaccine is recommended for persons at increased risk of influenza-related complications and all others who would like to reduce the chances of becoming ill with influenza.

Clinical Information

Cough/Bronchitis

- Cough/bronchitis is principally caused by viral pathogens.^{2,3} Airway inflammation and sputum production are non-specific responses and do not imply a bacterial etiology.
- A critical review of the six randomized trials (adults) concluded that antibiotics were ineffective in treating cough/bronchitis in otherwise healthy persons.⁴

Pharyngitis

- Most sore throats are caused by viral agents.⁵
- Although clinical findings do not accurately distinguish between streptococcal and non-streptococcal pharyngitis,⁶ the presence of rhinorrhea, cough, hoarseness, or conjunctivitis strongly suggest a viral etiology.⁷
- Rapid (antigen) tests or a culture should be positive before beginning antibiotic treatment.⁸
- To prevent acute rheumatic fever, antibiotics may be started up to one week after the onset of symptoms.⁹

The Common Cold

- Cough and nasal discharge may persist for 14 days or more after other symptoms have resolved in uncomplicated colds.
- Controlled studies do not support antibiotic treatment for the vast majority of patients with mucopurulent rhinitis.¹⁰⁻¹¹
- Do not over-diagnose sinusitis. Many viral upper respiratory infections may involve the paranasal sinuses; yet, only a

small minority are complicated by bacterial sinusitis. Rhinorrhea or persistent daytime cough beyond 10-14 days without improvement or fever with purulent nasal discharge, facial pain or tenderness, and periorbital swelling suggest bacterial sinusitis.

Otitis Media

- Antibiotics are indicated for acute otitis media (AOM) but not for initial treatment of otitis media with effusion (middle ear effusion in absence of ear pain, fever, or bulging yellow or red tympanic membrane).
- Amoxicillin remains highly effective for AOM and is recommended as the first-line antibiotic by most experts.¹²
- Antibiotic prophylaxis for recurrent AOM should only be used when clearly indicated (≥ 3 distinct, well documented episodes of AOM in 6 months or ≥ 4 in 12 months).

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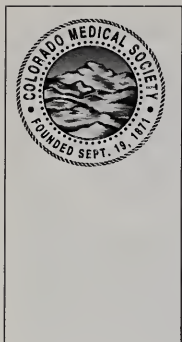
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ACCOUNTABILITY

by Byron D. Jones, M.D.
Denver Spine & Rehabilitation Clinic

Outcomes From The Clinician's Perspective

Over the past few years, "outcomes" has become a **major**, if not **the** buzz word in the medical profession. It is rare to pick up a journal where this concept is not mentioned. As both a clinician and an administrator, I find current trends in outcomes analysis to be exciting, confusing, and at times alarming. It seems everyone has jumped on the bandwagon, from administrators of large health care plans, to medical consulting firms to individual clinicians. Each of these groups have their own interests in looking at outcomes, with potentially beneficial yet possibly conflicting results.

Clinicians in private practice are now challenged to become proficient in an increasing number of areas, from business to medicolegal concerns. We are now also entering into an age where we must adapt to new available information technologies. This includes understanding the concepts and intricacies of profiling, statistics, and quality improvement. Somewhere along the way, there is also something called patient care, which I still would like to believe is the reason most of us went into medicine. So how do we try to put all of this into useful perspective? Where is all of this to take us? What role can and should we have in this discussion? I believe it is vitally important that clinicians embrace and learn to use the processes of

data collection/analysis as well as quality improvement to ensure the direction and quality of medicine is not compromised. And I fear if we do not, others with far less desirable ambitions may decide things for us. In the two previous articles on this subject, Dr. Calonge and Dr. Shapiro have given excellent discussions of some of the issues. I would like to concentrate on additional issues clinicians might want to consider.

Some of the following ideas have been touched upon previously but bear repeating. The entire concept of outcomes analysis needs to be about patient care. We must remember we are clinicians first with a goal of maximizing the efficacy of care while maintaining quality. If we forget this, we will ultimately fail. Our industry has reached a point where no longer is it acceptable to simply state "my results are better than yours", "my costs are justified", or "you can't compare my outcomes with yours because my patients are different than yours". We must now be able to prove these assertions in a scientific manner. While most of us are neophytes at this, it does not preclude us from starting the process. In fact, by beginning the process we may be surprised at some of the benefits. It is not necessary to view outcomes as something only research institutions should perform, nor is it necessary to have a sophisticated information technology system nor extensive research experience to obtain meaningful results. The available information technologies now make it possible for us to perform useful analyses on a more individualized basis. What is essen-

tial is having an open mind and the ability to use the information to make appropriate changes in our practices, when necessary.

The concept of "outcomes" seems to encompass many different ideas. I have seen it describe everything from practice trending to prospective, randomized, double blind, controlled analyses. All of these are important in their own ways and can be beneficial to clinicians. For instance, practice trending can be extremely useful in directing and achieving long term goals. The measurement of waiting times, referral sources, and patient satisfaction can have dramatic positive effects on our practices. Functional assessment of our patients can lead to great advances in new or untested forms of treatment. To date, most practices have not undertaken these types of analyses. Many of us feel strongly we know our outcomes and what needs to be done. When one actually begins measurement, however, you may be surprised to learn you are wrong. I believe these types of measurements will be the means by which we either succeed or fail in our private practices. Payers, employers and managed care organizations are already doing profiling on their own, and in the not too distant future may begin using "report cards" to determine whether or not we will be participants in their plans. Some are already using this type of analysis to determine the types of treatments they will authorize.

"Information is not the same as knowledge, and neither should be

(Continued)

confused with wisdom". We must use data collection as a tool, much like we use other diagnostic testing. Caution needs to be taken in not allowing it to take the place of our judgment and other medical knowledge in treating our patients.

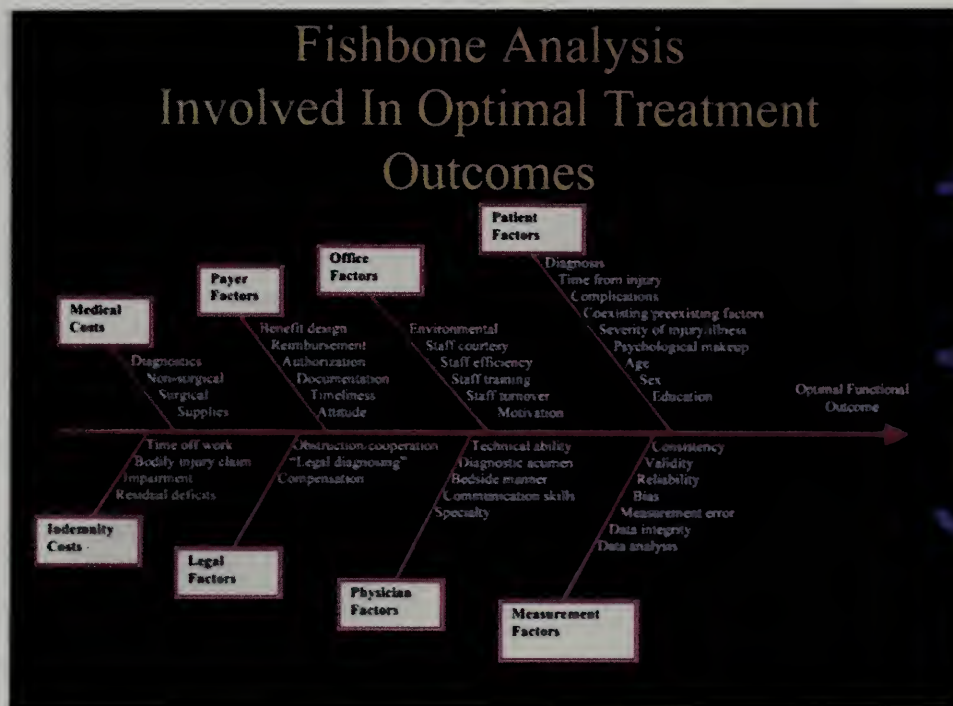
There are a number of other considerations in beginning this process. Who should be measuring outcomes? Clinicians? Specialty groups? Medical Societies? Payers? Carriers? Managed Care Organizations? At present all have plans to do so, and possibly, all can and should. These groups may have different interests, but also have some in common which can be complementary and synergistic. My interest as a clinician may be in my use of MRI scans and their correlation with my examination, and/or return to work rates. The payer's major interest may be strictly the number of times I'm ordering an MRI and the total costs associated with the MRI's. Again, both measures may be valid, but may or may not be useful in the other's analysis. I believe we will all learn from this undertaking. And I fear we will all lose in part by not being a part of the process.

What is the risk of not measuring outcomes? Why should I measure this when I know "they" will anyway?. Let's take a managed care organization as an example. With their outcome measurement system, **they** will control the data, **they** will determine the parameters to measure, **they** will determine the methodology and application of that methodology. You will be dependent on their data for feedback, and the information may be used in your "report card". Some of these groups may not have that much expertise in doing so, and the conclusions they come to could be erroneous. As a clinician, your desired performance parameters may be different and not even measured using their methodology, and you may not even agree with their methodology. Without your own independent measurement, you have no means of disputing/verifying their results, or determining your own desired outcomes. There may be an extremely important parameter they are missing.

Another big concern with managed care organizations and payers is many times their collection is largely based on claims data, which is only a part of the larger issue of efficacy of care. Each clinician must judge for him/herself whether they wish to perform individual assessments or are willing to accept the information by others. Should you wish to accept other's information, I still believe it is necessary to understand the methodology used in obtaining this information.

like we have very little. We are beginning to see groups of physicians pooling data comparing costs and functional outcomes within their practices and specialties and performing cross comparisons. This type of information can potentially have a profound impact in discussions with patients, employers, and payers.

What things need to be considered when setting up an outcomes system and project? The first is establishing goals of performing the



(Figure 1)

The costs of performing these types of analyses are considerable and cannot be ignored. As with other things, it comes down to the cost:benefit ratio. The costs are both direct and indirect. Hardware, software, programming and measurement services must be factored, as well as the indirect considerations of your time and that of the staff. I believe the benefits far outweigh this. The information that can be gained is an extremely powerful objective tool to evaluate one's practice. This information can be used for marketing purposes, for contracting more favorable reimbursement rates, and in the more altruistic pursuit of better medicine. It short, it will help control your destiny and gives practitioners power at a time when we all feel

analysis. Who is it for and what will I do with the information? Am I trying to establish a valid, scientific study or simply improve the efficiency of my practice? Both are important but require entirely different levels of time and expertise. An analysis of patient satisfaction within one's practice obviously does not take nearly the scientific rigor of a functional outcome assessment that is prospective, randomized, controlled, double blind, and demonstrates statistical significance. If you are the type who does not wish to know or will likely not use the collected data, do not bother to even collect it. Second is a basic understanding of data collection. Most systems require rather strict,

(Continued)

Outcomes From The Clinician's Perspective

(Continued from preceding page)

accurate data entry. For instance, if the same patient is entered into a data base as J. Smith, John Smith, or John R. Smith on three successive office visits, he will be interpreted as three different patients, thereby inaccurately affecting results.

Third, understanding the concepts of benchmarking and validity is important. There are times when no benchmarks for your outcome exist. This should not cause one to abandon a project but may require alteration in study methodology. And finally, standardization of definitions, treatment protocols, and measurement tools is extremely important. We want to be measuring parameters that allow apples to apples comparisons. Let's take lumbar radiculopathy as an example. If I am trying to establish how my surgical functional outcomes for lumbar radiculopathy compare with that of my peers, or possibly other specialists performing an identical procedure, I need to know concrete definition parameters? How far down the leg does the pain have to go to be called radicular? To the buttock? The thigh? The lower leg? The foot?. Are reflex and motor changes required? If we cannot agree on the definitions the outcome measurements may not be valid. In many disease processes, definitions and treatment parameters are vague and inconsistent. The larger groups such as the specialty boards and medical societies may be able to assist greatly in facilitating standardization of these parameters. Likewise, standardization of study methodology is crucial for the same reasons.

When setting up a system, a few thoughts come to mind. Up front planning can save a lot of problems down the line. This includes what type of hardware and software will be necessary as well as the goals, definitions, and methodology of the analysis. It really is not necessary to have an expensive, sophisticated system to begin analysis. There are a

number of practitioners who are doing excellent tracking on fairly basic PC (personal computer) systems. Too much planning, however, can be a detriment to getting started. More and more we are being urged to move to action. It is not always necessary to have the perfect study protocol to begin measurement, especially if we are simply trying to improve trends. You will also learn things from your preliminary results that may change your goals and methodology or even the entire project. Considerable research is under way in determining the most valid patient questionnaires, functional scales, etc. We should try to use the best tools available, realizing many and most of these have not undergone strict scientific scrutiny.

For those who are neophytes, the KISS (Keep It Simple Scientist!) principle definitely applies. Quality Improvement tools such as fishbone analyses can be helpful in determining factors to consider and the likelihood of these factors in effecting a desirable change (figure 1). Multiple texts are available that cover these in more detail.

To ensure quality in determining outcomes, valid independent verification is desirable and often necessary. Many clinicians have undertaken small clinically driven outcomes analyses within their practices and have attempted to use these for marketing purposes.

We have all seen these types of studies, many of which are not scientifically valid and cannot be replicated in larger trials. They are generally met with suspicion and only serve to undermine the credibility of our profession when used inappropriately. These types of studies, however, can serve as a great source of information as building blocks for larger studies, which can be used in a more meaningful fashion. Purchasers of health care and managed care organizations are quite interested in these types of studies.

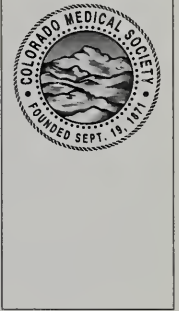
A last word regarding the managed care organizations, carriers/payers and their role in assisting in outcomes analysis. They can serve

as an important data collection system and means by which to disseminate information. For instance, they are in a fairly unique position for us to determine things such as recidivism, total costs of care, and retention. Most of us would like to believe that we have effectively treated our patients at the time of discharge. I have been impressed at the number of times this is not the case.

Treatment often continues with another provider when the outcome is not optimal in their minds. These are parameters most of us in private practice cannot measure and are likely of great interest.

As we move toward the future, it is likely a number of changes will occur. We will almost certainly develop better standardization of measurements and definitions, facilitating the apples to apples comparisons we desire. I believe both education of clinicians and information technologies will become even more user friendly in assisting us in data collection and analysis. We already are seeing integrated paperless systems that will facilitate analysis from billing, scheduling, and medical records. Clinicians and academic researchers are becoming increasingly concerned about inappropriate direction of care without a scientific basis. This will hopefully lead toward better scientific collaboration by the appropriate experts in defining what is medically reasonable and cost effective care. It is likely the financial concerns of purchasers of healthcare will continue to drive us to determine best practices. Outcomes assessment will be increasingly used in marketing and contracting by practitioners. My hope is this will be a cooperative endeavor among clinicians, managed care organizations and payers. If we can all come together, I believe it will result in a better patient care system.

The next generation of healthcare will almost certainly be driven in part by this movement. We must begin to work together to use this information appropriately. If we do not, others will attempt to do this for us.



John L. Lightburn, M.D.
Historian, Colorado Medical Society

The Story of Ingraham and Taylor, a Connecticut Yankee and a Gentleman from South Dakota

Introduction:

When I started working on a brief history of obstetrics and gynecology in Colorado, I found that it closely paralleled the history of the Department of Obstetrics and Gynecology at the University of Colorado School of Medicine. After interviewing E. Stewart Taylor, M.D., reminiscing about the "good old days" at medical school, I decided to devote this article to a history of the teaching of obstetrics and gynecology at the University. I am indebted to Dr. Taylor for sharing his knowledge and insights.

John L. Lightburn, M.D.
CMS Historian

In 1883, the Board of Regents of the University of Colorado directed President Joseph A. Sewall, who had both an M.D. as well as a Ph.D. in chemistry, to establish a medical department on the campus at Boulder, competing with the University of Denver which had opened its medical department two years earlier. With grand plans to have a medical school equal to any in the country and a four year curriculum, the school's inception was modest. Requirements for admission were a high school diploma and a matriculation fee of \$5.00. There was no tuition. The faculty consisted of President Sewall, who was the dean of the school and Professor of Chemistry, and Dr. W. R. Whitehead, M.D. who commuted from Denver to teach anatomy and surgery. The first class had two students. By 1884, seventeen students were enrolled and the faculty was ex-

panded by five more, including two Boulder physicians, one of whom was Dr. T. H. Everts, the school's first Professor of Obstetrics and Diseases of Women. In 1885, a 30 bed hospital was built on the southwest corner of the campus and clinical teaching became a part of the course. Those early years were difficult. On at least two occasions the legislature considered closing the school, calling it a waste of taxpayer's money. But with the



E. Stewart Taylor, M.D.

dedication of the faculty, especially the volunteer medical faculty, and the support of the medical society, the school survived and grew. With the population of Boulder less than 5,000, the opportunities for clinical teaching, especially in obstetrics, gynecology and surgery, were much greater in Denver. The University arranged for third year students to have some clinical teaching at the Arapahoe County Hospital in Denver. But the state constitution required all schools of the University to be in Boulder. and the Supreme

Court ordered the school to cease teaching in Denver. After years of political maneuvering, a constitutional amendment was passed by the voters in 1910 which allowed the last two clinical years to be moved to Denver.

The Denver division of the medical school was set up in rented space in the old Archer mansion at 1307 Welton Street. This was an impressive mansion, but ill adapted for a medical school with two class rooms, two small offices, a laboratory on the third floor (or attic), a pharmacy tucked under the stairway and a clinic in the basement. The Denver and Gross Medical College had fallen on hard times and after months of negotiation was merged with the University Medical School in 1912, bringing a number of colorful men into the obstetric faculty (Thomas Hawkins, Francis McNaught and Joseph Hutchinson). These volunteer faculty members did their clinical teaching primarily at Arapahoe County Hospital (later to become Denver General Hospital) and at St. Joseph and St. Luke's Hospitals which overcame some of the inadequacies of the Archer Mansion. Young physicians from eastern schools continued coming to Denver and, eager to establish themselves, joined the volunteer faculty. One of these young stalwarts was Clarence Bancroft Ingraham, a name some of you may remember. He became a major player in obstetrics and gynecology in Denver. Joining him a year later was Cuthbert

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Powell. These two men were still teaching as volunteer faculty until 1946. Dr. Ingraham had come from Connecticut and was a graduate of Yale and Johns Hopkins Medical School. He then was a house officer under Dr. Howard Kelly at one of the finest residencies in the country. Cuthbert Powell, on the other hand, was a native of Colorado and a graduate of the University of Denver Medical Department.

At the same time Ingraham and Powell had joined the faculty, young Charles N. Meader, with his M. D. degree from Harvard, also joined the faculty as an assistant professor of medicine. Dr. Meader was ambitious and hard working and by 1916, he



Medical School Building
Denver, 1911-1924

was appointed Dean of the School of Medicine. His goal from the beginning was to establish a bona fide medical campus and teaching hospital in Denver. Taking one step at a time, his first move was to reorganize the faculty into departments. He asked Dr. Ingraham to become the first Chairman of the Department of Obstetrics and Gynecology, a position he held for 30 years. Keep in mind that all of the clinical faculty were unpaid volunteers. What a truly dedicated man he was, serving as chairman for 30 years! I was one of his students and we called him "Tuffy Ingraham." But he was respected as a skilled and compassionate teacher and physician. Early in his teaching, he compensated for the inadequacies of the Archer mansion and the clinical facilities by organizing a formal obstetrical course using a manikin.

Every student was offered this course in small groups.

As early as 1912, the A.M.A. Council on Medical Education had found the school woefully inadequate, especially the teaching facilities in Denver and also the loosely organized volunteer teaching. The commission made several recommendations, but before Dean Meader could implement the changes, the United States became involved in World War I. Much of the faculty, including both Ingraham and Powell left to serve in the Army Medical Corps. When they returned in 1919 to resume their teaching, Dean Meader was working on his expansion plans. Although physicians like Ingraham and Powell gave dedicated service, the school was still in trouble. Dean Meader, frustrated by lack of funds and an unsympathetic Board of Regents, had been unable to implement the important features of these recommendations. But the country was in an expansive and prosperous state. The Rockefeller Foundation offered the school \$700,000 to build a new school in Denver if Meader could find matching funds locally. With the help of the Medical Society and various public-spirited citizens, he raised the necessary funds. F. G. Bonfils gave the school 17 acres of land at Colorado Boulevard and 9th Avenue. Critics said that was too far out in the country! A constitutional amendment to move the entire school to Denver was passed. Numerous other obstacles were overcome and the new medical campus of Dean Meader's dreams became a reality. A new, \$2,100,000, state of the art medical center was dedicated on January 23, 1925. In 1926, Dean Meader stepped down, returning to private practice and a position of Professor of Medicine on the volunteer faculty, which was still unpaid and part time. C.B. Ingraham was still Chairman of the Department of Obstetrics and Gynecology. He struggled to have a good teaching service and recruited a number of respected physicians for the faculty, including E. L. Harvey, Lyman Mason, Warren Tucker,

Eugene Auer and Bert Jaffa. As new men came to town, Professor Ingraham encouraged them to become active members of the faculty. He often took them into his private office to help them become established in Denver. The students had a six week clerkship in obstetrics in their third year and a six week clerkship in gynecology in their fourth year. The home delivery service was established in 1927 with the Denver Visiting Nurse Association. Each student was required to complete four home deliveries before graduating. The service continued for twenty years and had the remarkable record of no maternal deaths.

Members of the faculty had no research funds or laboratory facilities, but they made important scientific contributions based on their clinical experience. Tuberculosis was a major disease in Colorado and several reports came from the department on the management of tuberculosis during pregnancy.

In spite of the efforts of Dr. Ingraham and his fellow volunteer faculty members, the school was in trouble again. The Great Depression had a devastating impact on all state institutions. A miserly legislature became even more tight fisted. In 1936 the Council on Medical Education and Hospitals of the American Medical Association gave the school very poor marks. Financial support was found to be miserably inadequate. The clinical departments were found to be inferior to the pre-clinical courses, and all but pediatrics received unsatisfactory marks. The committee found the teaching to be uncoordinated and strongly urged the establishment of full time clinical faculty. When an evaluation committee from the Association of American Medical Colleges dropped by in 1940, they found that little had changed. The state legislature, dominated by agriculture and mining, continued to deny the school adequate funding. Before corrective action could be taken, the country became embroiled in World War II and all resources were dedicated to winning the war. For four years, the school

limped along with a drastically reduced faculty. The teaching and clinical work in Ob-Gyn was carried on by Drs. Ingraham, Powell, Mason and Auer. These were dark days, but after the war, a new day was to dawn under the leadership of a new dean, Ward Darley.



"Old Main" CU Boulder

Before proceeding with our story, let us go back to 1911 when Dr. Ingraham was beginning his work in Denver. In Hecla, South Dakota, a first son was born to a young Irish immigrant and his bride on August 20, 1911. He was the first of five children, all delivered at home by a general practitioner. Three of the boys grew up to be physicians. The first born was talented academically and was graduated from the University of Iowa School of Medicine in 1936, then served an internship in Flint, Michigan, followed by four years of residency in Obstetrics and Gynecology at Long Island Medical College, 1937 to 1941. During his residency, he fell in love with a young woman he had known back in South Dakota who had come east to attend Teachers' College at Columbia University. This young physician's name was E. Stewart Taylor. After serving in the Army where he saw service on the Normandy beachhead, he decided to come to Denver. His mentor at Long Island, Dr. Alfred Beck, had recommended him highly to his old friend, Clarence Ingraham. As usual, Dr. Ingraham invited Dr. Taylor to join his private practice and to come on board the volunteer faculty. Ward Darley liked the young obstetrician and offered him the first full time position in the Department of

Obstetrics and Gynecology. In persuading Dr. Taylor to accept the position (with pay of only \$7000) Dr. Darley pointed out that Dr. Ingraham was about ready to retire and the chair of the department would soon be vacant. So in spite of a meager salary and some onerous restrictions, he accepted the position of associate professor. One year later, Dr. Ingraham did retire and Dr. Taylor became Professor and Chairman at the age of 36. He quickly began to make changes in the department. First was the creation of a four year residency following a year of a rotating internship. With only one resident on board, he recruited three more from the University of Chicago. As important as the restructured residency was, the creation of a research department was of equal importance. For this he recruited Dr. Paul Bruns from Johns Hopkins. Taylor and Bruns were admired by all their students and residents, truly wonderful mentors and role models.

One of more interesting research developments in the department was diagnostic use of ultra sound. It turns out that ultrasound was the brain-child of a medical student, Douglas Howry. The idea had come to him as he was being shipped overseas on a troop ship as an infantry officer. He was fascinated by the sonar on board the transport ship and wondered if a similar principle could be used in diagnostic medicine. Following the war, he returned to medical school. He was so preoccupied with developing this new invention that he flunked out. But Dr. Taylor, chairman of the promotions committee, was convinced that young Howrey was on to something and recommended that he be given another chance and allowed to graduate in five years. In 1950, Dr. Howry's invention caught the eye of Dr. Joe Holmes in the Department of Medicine. Working with Dr. Holmes and Dr. Bouslog from radiology, Doug Howry constructed the first ultrasonic scanner in his basement. While Holmes and Howry were working in Denver, Dr. Ian Donald was also working on ultrasound in Scotland and published an article. Dr. Horace Thompson showed the

article to Drs. Taylor and Holmes who found some grant money to funnel to Dr. Thompson and chief resident, Dr. Kenneth Gottesfeld who did clinical research on volunteer patients from the Florence Crittendon Home for unwed mothers. The result of all this was a paper by Drs. Taylor, Thompson, Holmes and Gottesfeld on the measurement of the fetal biparietal diameter by use of ultrasound, the first paper on ultrasound to be published in the United States.

Under Dr. Taylor's leadership, the department and the entire school grew and prospered. From one full time faculty position, the department grew to 18 full time faculty. In trying to summarize the accomplishments of the department, we can first mention that approximately 8,000 medical students were given a good foundation in obstetrics and gynecology. One can see the result of this in the state's perinatal mortality rates. In 1951, the rate was 3.6%, and Colorado ranked 35th in the nation. In 1981, the perinatal mortality rate was 1.2%, making Colorado rank number two in the nation. One hundred fifty residents have finished their training at the University. Colleagues have described Dr. Taylor as a "masterful surgeon". After many encounters with incredible trauma in the service, "nothing frightened him in the O.R." Perhaps his greatest contribution was what evolved from his foresight, innovative teaching and commitment to understanding and preventing prematurity: the development of the field of perinatology.

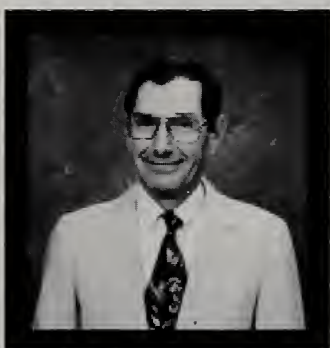
The profession and the state are indebted to two great men: Clarence Bancroft Ingraham and E. Stewart.

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In Memory Of...

by Robert S. Seigel, MD
Paul K. Danner, MD



Neal Goodman, M.D., F.A.C.R.
Mar. 22, 1934 — Dec. 11, 1997

"What lies behind us and what lies before us are small matters compared to what lies within us."

Ralph Waldo Emerson

Within Neal Goodman was a man of virtue and intellect and achievement. He lived an authentic and exemplary life as a physician, teacher, husband, father, and grandfather. He was born at St. Anthony Hospital in Denver, Colorado on March 22, 1934. He graduated from the University of Denver and subsequently The University of Colorado Medical Center. After a residency in Radiology at the University of Colorado Medical Center, he studied chest radiology with Dr. Ben Felson at the University of Cincinnati. Neal eventually became an Associate Professor of Radiology at the University of Colorado Medical Center before joining the St. Anthony Hospital Radiology Department in July 1967, bringing with him the first skills in nuclear medicine and angiography. He was always a friend and teacher, not only to his partners and colleagues but also to the radiologic technologists and others with whom he worked. He worked tirelessly to improve both himself and those around him.

Neal faced a difficult choice as a young man when he won scholarships both to the prestigious Berkley School of Music in Boston and a Boettcher Scholarship which would allow him a free education at any school in the state of Colorado. His mother was instrumental in his decision to become a physician rather than a professional musician. Neal always loved his music and was one of the premiere jazz pianists in

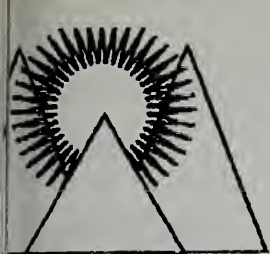
Denver. His group, "Jazz West", often played at the Mercury Cafe. His first words to his new partner, Mike Foster, in 1988 were: "Can you play the drums?" When Mike said no, Neal replied, "Well Great! We've got plenty of radiologists; I need someone who can play the drums!" (Which is but one of a myriad of "Neal stories" that we fondly recall on almost a daily basis).

Neal loved to read and discuss issues relating not only to medicine but also to golf, music and philosophy. Neal's remarkable intellect will be greatly missed in our reading room which was truly his domain and from which he dispensed so much wisdom over these past thirty years. His quick wit and humor always made for a relaxed atmosphere and kept all things in proper perspective. Indeed Neal was a man whose inspirational legacy will be remembered always.

Contributions are welcome through the St. Anthony Health Foundation in order to establish "The Neal Goodman Breast Center" at St. Anthony Central Hospital, 4231 W. 16th Ave., Denver, CO 80204.

Editor's Note:

Drs. Seigel and Danner were partners of Dr. Neil Goodman.



Rocky Mountain Primary Care

January 26, 1998

To My Patients:

It is with sadness that I write this letter to you. I was diagnosed in June with a severe form of systemic lupus which involves my heart and lungs. The lupus is complicated by myasthenia gravis which paralyzes the diaphragm, larynx and eyes. Despite various treatments, these symptoms have not gone into remission so I remain extremely ill. I will be on life-long chemotherapy which will prevent my seeing patients and practicing medicine. I want to spend my remaining time in the arms of my husband and four children.

The practice of medicine is a sacred trust and it has been my extreme privilege to have been a part of your lives for the past 12 years. My patients mean so much to me. I want to assure you that your care is in the best of hands with my practice partners, Deborah Way, M.D., Marc Morse, M.D., Cindy Riegel, M.D., John Nielson, CFNP, and my newest partner, Tracy Saffer, M.D. In order to protect the continuity of your care, we will be changing your primary care physician to one of my partners. Our office has the appropriate forms to choose another physician, or you can contact your insurance carrier.

I know of no more caring doctors and staff than those at the five offices of Rocky Mountain Primary Care. They are there to help you receive the highest quality of medical care. I sincerely regret any inconvenience this may cause.

Again, thank you for allowing me to have been your physician. You will be in my thoughts. I would be happy to hear of your progress and I am able to receive mail from the office.

Most Sincerely, Your Physician

Jan M. Kief, M.D.

JMK/sky



Copic: Addressing Accountability for Clinical Outcomes

By now, CMS members should be well aware of the Society's renewed focus on accountability for clinical outcomes, spearheaded by Dr. Gary VanderArk and outlined in his editorial in the November, 1997 issue of *Colorado Medicine*. Just like the Society, Copic is also intensely concerned with this issue. In this article, I want to give you some background on the rationale and genesis of the loss-driven, risk-based disease management seminars we are currently developing for policyholders.

In a disease management model, medical resources are coordinated for patients across the entire health care delivery system. This approach differs greatly from traditional medical care, shifting the focus from treating patients episodically to providing high-quality care throughout the continuum from prevention to resolution. This necessitates the involvement of primary care givers (not just the physician); diagnostic specialists (radiologists and pathologists); therapeutic interventionists (surgeons, medical and radiation oncologists, and plastic and reconstructive surgeons); and rehabilitation specialists (including physical and occupational therapists).

As shown in the following table, a mere five medical conditions are responsible for almost two thirds of the costs incurred by the professional liability insurance industry between 1991 and 1995. Copic's paid claims differ somewhat from industry norms. For

Physician Insurers Association of America Paid Claims Closed Between 1991 and 1995

Rank	Medical Condition	% of Costs
1	Brain damaged infant	37%
2	Breast lump/breast cancer	13%
3	Acute myocardial infarction	6%
4	Colon and rectal cancer	4%
5	Lung and respiratory cancer	4%

example, due primarily to our efforts and yours in both family practices and specialty-based obstetrics, losses from claims involving brain damaged infants have decreased significantly.

Under the direction of George O. Thomasson, M.D., Vice President of Risk Management, Copic is developing disease management seminars to address areas of disproportionate risk revealed by our Colorado-specific loss experience. These areas include:

- Breast lump/breast cancer
- Chest pain/acute myocardial infarction
- Colon/rectal cancer
- Prostate cancer
- Drug reactions

According to Dr. Thomasson, these areas lend themselves naturally to the disease management model since each condition or complaint presents potential "trouble areas" for almost any physician, regardless of specialty.

Much progress has been made at Copic since I last wrote to you about our efforts regarding disease management (May, 1997). We will soon introduce a new risk management

lecture on breast lumps/cancer incorporating information for family physicians, internists, obstetricians, gynecologists, radiologists, oncologists, general surgeons, and radiation oncologists. The seminar will explore the medicolegal pitfalls of breast lump/breast cancer management and will also address guidelines for patient care.

The curricula for the other two seminars we're developing are also shaping up nicely. The chest pain seminar will incorporate information for family physicians, internists, cardiologists, cardiac surgeons, and emergency medicine physicians. A seminar on laparoscopic cholecystectomy is also planned for family physicians, general surgeons and others.

The acid test of any disease management seminar we develop will be whether it is both sufficiently general and sufficiently specific to address the roles played by both the primary care provider as well as the specialty-specific physician(s). I am confident you will find that our new seminars will more than meet the test.



The dizzying pace of technological change in the health care sector marches on, and every day hospitals, clinics and doctor's offices in Colorado and across the nation replace old medical equipment and supplies with new tools and products. Unfortunately, much of that equipment finds its way to landfills despite the desperate need for such supplies in Third World countries. Project CURE, (Commission on Urgent Relief and Equipment) a locally run non-profit organization, has championed the belief that medical surplus can be recycled for use in under-served nations. **Colorado Medicine** ran a feature story on Project CURE in April of 1996. Since that time knowledge about, demand for and supply of equipment by Project CURE has also grown at a dizzying pace.

Founded in 1987 by international economist Jim Jackson, Project CURE (Commission on Urgent Relief and Equipment) ships hundreds of tons and millions of dollars of medical supplies and equipment have helped save thousands of lives in third world countries all over the globe. Each country receiving supplies from Project CURE first goes through a needs assessment. Then a customized shipment of donated supplies is assembled. At least \$5000 must be raised to send containers overseas. Because of Jackson's international connections and expertise with political red tape, Project CURE can boast a perfect 10 year track record of medical items arriving at their appropriate destinations.

Now, more than ever, Project CURE needs your help. Hundreds of

volunteers are gathering, packing and sending our medical discards in immense land/sea cargo containers for shipment throughout the USA and 58 medically under-served emerging nations. Sixty more countries are clamoring for assistance.

Technologically advanced market forces in America are the primary source for the second generation equipment and overstocked supplies needed by Project CURE. Almost no one questions the problem of medical waste in the U.S., yet hospitals routinely throw away or lease space to store their obsolete equipment. Every hospital, clinic, doctor, nurse, medical facility administrator, pharmaceutical representative, medical supply company and others should make boxes marked Project CURE available for personnel to deposit any and all surplus medical and surgical supplies. No item is either too big or too small. Everything will be used, from sutures, bandaging, glass thermometers and pens to computers, exam tables, office furniture, autoclaves and x-ray units. All donations are tax deductible, and many of you might find it more cost effective upon retirement, relocation or remodeling to give your office supplies to Project CURE rather than selling it for 10 cents on the dollar.

Project CURE has its world headquarters in Denver and has a 55,000 square foot warehouse at Stapleton. We now have seven pickup points around the country and are looking for coordinators and warehousing in Chicago, the East Coast and the San Francisco Bay area.

"... make boxes marked Project CURE available for personnel to deposit any and all surplus medical and surgical supplies."

For more information, or if you need to have your donations picked up or you know of any volunteers to help with pickups, sorting, packaging and shipping costs, please call 303-727-9414. Thousands of lives have been saved by this recycling effort. Please help us in this effortless way to save thousands more.

Who's

WATCHING OUT For You?

From providers to community leaders, researchers to educators, and government officials to citizens, the National Rural Health Association's members seek to improve the health care of rural Americans through advocacy, communications, education and research.

The National Rural Health Association and its members work to overcome rural health care challenges. They focus on reforming and strengthening health care to meet the needs of rural areas. While government funding continues to dwindle, this multi-disciplinary group of health professionals and leaders finds innovative solutions to complex dilemmas.



NATIONAL RURAL HEALTH ASSOCIATION — *Caring for the Country*

For more information, contact the NRHA,
One West Armour Boulevard, Suite 301, Kansas City, MO 64111;
816-756-3140; fax 816-756-3144.

So Who's Got Money To Burn These Days.

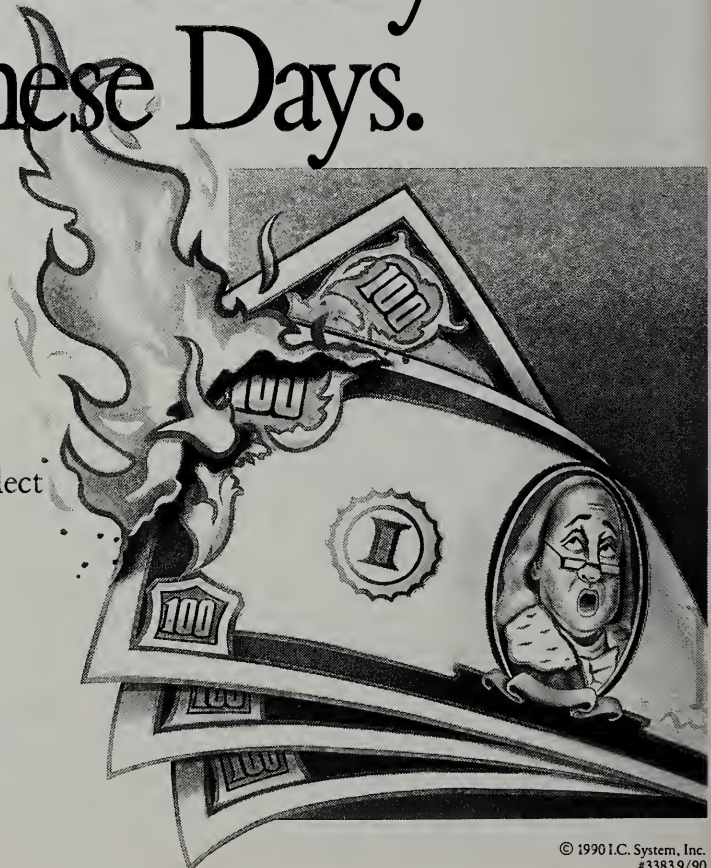
American businesses watched 22 billion dollars in unpaid receivables go up in smoke last year. How much money are you letting vanish into thin air?

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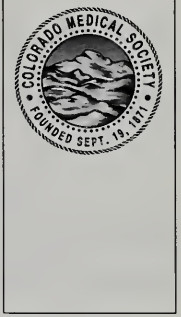
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Specialty designation is important

In these days of heightened awareness of Medicare audits there is one easy way to avoid becoming a "target". That is, to be sure your specialty designation on Medicare's records correctly reflects your current practice. The specialty designation is identified by the physician when applying for a Medicare provider number. (The Medicare provider file can accommodate two specialty designations.)

Even though Medicare no longer ties the specialty designation to reimbursement, it is still very important. This designation determines the peer group which will be used for comparison of the physician's practice patterns. "Aberrancies" can sometimes be caused by not having the correct subspecialty listed. For example, a general surgeon who specializes in vascular surgery should be sure that the Medicare file shows both general surgery and vascular surgery.

If you aren't sure what specialty you designated, or if you need to change your specialty you can do so by writing to the Medicare Carrier. For Colorado send a letter identifying the specialties you want reflected on your record to:

Medicare Part B

Attn: Provider Network
730 N. Simms St., Suite 100
Golden, CO 80401-4730

If you have questions, contact Marilyn Rissmiller, CMS Health Care Financing Department at 779-5455 or 1-800-654-5653, ext. 2428.

Level II Physician Accreditation Seminar

The Colorado Department of Labor and Employment, Division of Workers' Compensation, will present a Level II Physician Accreditation seminar on February 20 and 21, 1998, at the Radisson North Denver Graystone Castle, 83 East 120th Avenue @ I-25, Thornton, CO.

The Level II Accreditation seminar is a series of lectures and workshops led by specialty experts on formulating impairment ratings utilizing the American medical Association *Guides to the Evaluation of Permanent Impairment*, Third Edition Revised. The program also outlines pertinent administrative and legal aspects of the Workers' Compensation system.

Cost of the seminar is \$375.00. To obtain a registration form or for more information, please contact the Physician Accreditation Program at (303) 575-8763.



<http://www.cms.org>

Stay in touch with
Colorado health care.

The Medicare Private Contracting Provision from the HMO side

A physician does not need to enter into a private contracting arrangement with a Medicare patient for *non-covered* services. This can include out-of-plan services for a Medicare HMO enrollee. When a Medicare patient chooses to see a doctor who does not participate with his/her HMO, the following applies:

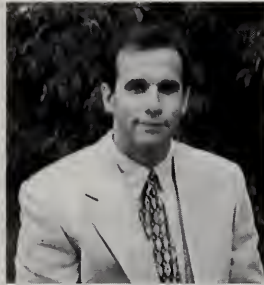
- In the case of a patient enrolled in a Medicare Risk HMO the patient is responsible for the non-covered services. You can bill the patient directly without entering into a private contract (in fact you should not enter into a contract).
- In the case of a patient enrolled in a Medicare Cost HMO the HMO is not responsible for the charges, neither is the patient. The non-plan services revert to the traditional Part B fee for service benefits and should be billed to the Medicare Carrier.

The terms **Risk** and **Cost** refer to how the HMO is reimbursed by Medicare. Currently in Colorado there is only one HMO enrolling Medicare beneficiaries on a Cost basis, that is Rocky Mountain HMO. For further information, contact Marilyn Rissmiller, CMS Health Care Financing Department, 779-5455 or 1-800-654-5653, ext. 2428.

(Continued on following page)

(Continued)

New CMS Health Care Policy Division director



*Chet Seward, Director
Division of Health Care Policy
Colorado Medical Society*

We are pleased to announce that the staff position vacated by Ellen Stein has been filled by Chet Seward, formerly a Communication Specialist at Colorado Medical Society.

Although Chet has some very large shoes to fill (that seems a strange statement to make concerning Ellen Stein, who is very petite), Chet seems to be a person well suited for the job.

Chet is known to many of the CMS members through frequent magazine articles and medical news stories, as well as having been involved in Member Services these past two years. Therefore, it seems unnecessary to present his resumé here once again.

The first big job for the Chet's Division will be to staff a Second Annual Conference of the Coalition for the Medically Underserved, which occurs in conjunction with the CMS Interim Meeting March 13, 1998, 8:00 A.M. to 5:00 P.M..

*Don't let them Suffer
In Silence!*

For additional resource materials,
contact Ellen Stein at the CMS
offices. 779-5455 or (out-state) dial
1-800-654-5653 or
E-mail: Suzi_Shevell@cms.org.

A Unique Fringe Benefit For CMS Members



Buying or Leasing a New Car???

The Colorado Medical Society now provides a professional fleet management service to assist members throughout the state when purchasing or leasing a new vehicle. This service provides valuable vehicle information such as factory invoice costs, available options, technical data, consumer reports, etc.

Once your selection is firm, your purchase or lease will be arranged at **prices normally available only to large corporate fleets.**

Colorado Medical Society has endorsed Rocky Mountain Fleet Associates as a CMS member service, based on the satisfaction of the many physicians who have used their services over the past several years. These physicians have reported excellent results, **usually with savings of more than \$1000 from even the best negotiated showroom price.**

For more details, call **(800) 864-4388**. In Denver, **753-0440**.

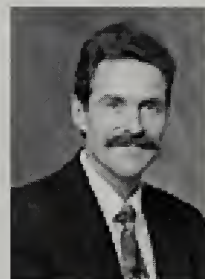
Colorado Medical Society

1998 Interim Session
of the
Colorado Medical Society House of Delegates
March 14-15, 1998, Denver Marriott Southeast (I-25 at Hampden)

General Membership Meeting Keynote Speaker
John C. "Jack" Lewin, MD

The General Membership Meeting will be held on Saturday, March 14, 1998, starting at 9:00 am. The meeting's keynote speaker will be John C. "Jack" Lewin, MD.

Dr. Lewin has had a varied career in medical practice, including primary care medicine, government health policy, the private sector health system and State health association management. He is currently the Executive Vice President and Chief Executive Officer of the 35,000 member California Medical Association, the nation's largest state medical association, and its nine subsidiary companies. He manages a staff of 150 and a budget of \$16 million. He assisted in the formation of a physician-owned, statewide health plan offering a variety of products to small and large employers. He also conceived and led development of that association's Institute for Medical Quality, an evaluation and accreditation agency focusing on quality of care by HMOs, hospitals and other health facilities.



John C. Lewin, MD.

Dr. Lewin serves on numerous boards, advisory panels and committees. His appointments include the Hepatitis Foundation International, the Public Health Foundation, The Partnership for Prevention, based in Washington, DC, and the California Governor's Council on Sports and Fitness.

His public service honors include awards from the US Public Health Service Commissioned Officers' Association (*Physician Leader of the Year*, 1994), the American Medical Association for HIV/AIDS prevention and treatment accomplishments (*Nathan Davis Award*, 1994), the American Hospital Association for improving private sector access to health care (*Justine Ford Kimball Award*, 1993) and the Association of State and Territorial Health Officials for public health leadership (*McCormack Award*, 1993). These accomplishments were built on a foundation of fifteen years experience as a primary care physician serving rural and underserved populations.

A nationally known speaker on health policy issues, Dr. Lewin has delivered more than 300 keynote addresses to health care and business audiences nationwide. He is regularly sought by major state and national media to comment on a variety of health care and policy-related topics. He is the author of numerous health policy and clinical medicine articles in a variety of professional and policy journals.

Dr. Lewin's career focus has been in the areas of health care for underserved populations, public health, public and private health care and hospital systems, state and national health system reform, managed care analysis, patient and physician advocacy and preservation of quality care in the American health care system.

For nearly eight years, as Director of Health for the State of Hawaii, Dr. Lewin managed 6,500 employees, oversaw a billion-dollar budget, and succeeded in creating policy that extended health insurance coverage and access to nearly all Hawaii's residents. In addition, Dr. Lewin was CEO of Hawaii's largest hospital system. Previously, in the last two years of seven years' service in the US Public Health Service, he founded and directed the tri-state Navajo Nation Division of Health to establish effective public health services and preventive medicine for a widespread population.

Dr. Lewin has led state and national legislative efforts on health system reform, health care access, and public health and safety issues and served for one year as President of the Association of State and Territorial Health Officials.

In addition, Dr. Lewin has developed and managed innovative public health programs in: HIV/AIDS prevention and treatment; prevention of child abuse and substance abuse; anti-tobacco education; food-product safety; and environmental health.

For five years Dr. Lewin served on the faculty of the University of Hawaii as a Clinical Professor of International Health. He earned his medical degree from the University of Southern California, after graduating from the University of California, Irvine with a BA. His subsequent training in internal medicine was at the University of Southern California/Los Angeles County Medical Center.

Colorado Medical Society 1998 Interim Meeting

Denver Marriott Southeast (I-25 @ Hampden Avenue)

Schedule

Friday, March 13, 1998

8:00 a.m.- 5:00 p.m..... Caring for Colorado's Underserved Conference
12:00 N- 1:00 p.m..... Lunch - Conference
1:00 p.m.- 2:00 p.m..... Finance Committee
2:00 p.m.- 5:00 p.m..... Board of Directors
5:00 p.m.- 6:00 p.m..... Registration
5:15 p.m.- 5:45 p.m..... Cocktails - Caring for Colorado's Underserved
5:45 p.m.- 7:45 p.m..... Dinner-Caring for Colorado's Underserved

Saturday, March 14, 1998

6:30 a.m.- 4:00 p.m..... Registration
7:00 a.m.- 10:00 p.m..... Office open
7:00 a.m.- 8:00 a.m..... Reference Committee Members Breakfast
7:00 a.m.- 8:15 a.m..... AMA Delegation Forum - open to all members
7:30 a.m.- 8:15 a.m..... COMPAC Board
8:00 a.m.- 8:30 a.m..... Credentials Committee
8:30 a.m.- 9:00 a.m..... House of Delegates
9:00 a.m.- 12:00 Noon..... General Membership Meeting
12:15 p.m.- 1:45 p.m..... Luncheon
2:00 p.m.- 4:00 p.m..... Reference Committee
3:00 p.m.- 5:00 p.m..... Reference Committee

Sunday, March 15, 1998

6:30 a.m.- 10:30 a.m..... Registration
7:00 a.m.- 12:00 noon..... Office open
7:00 a.m.- 8:30 a.m..... Arapahoe caucus
7:00 a.m.- 8:30 a.m..... Aurora-Adams County caucus
7:00 a.m.- 8:30 a.m..... Boulder caucus
7:00 a.m.- 8:30 am..... Clear Creek Valley caucus
7:00 a.m.- 8:30 a.m..... Denver caucus
7:00 a.m.- 8:30 a.m..... El Paso caucus
7:00 a.m.- 8:30 a.m..... Larimer/Weld caucus
7:00 a.m.- 8:30 a.m..... Pueblo/Western Slope caucus
8:15 a.m.- 8:30 a.m..... Credentials Committee
8:30 a.m.- 12:00 Noon..... House of Delegates

Colorado Medical Society Alliance MEETING AGENDA

at the

1998 Colorado Medical Society Interim Meeting

March 13-14, 1998 • Denver Marriott Southeast

Friday, March 13 6pm Board Dinner/notebook exchange
Saturday, March 14 8am Board meeting
" " " 9:30-am 12:00 N General Meeting
" " " 12:-1:30 pm Lunch/Installation of Officers
" " " 1:45 - 3:00 pm "Create a Winning Wardrobe"
Ann Fulton: The Total Look

**This portion goes
to CMS**

Interim Meeting Registration

1998 Interim Meeting of the Colorado Medical Society, March 14-15, 1998, Denver Marriott Southeast

Name (*Please type or print*) _____

Name of Spouse/Guest (if attending) _____

Component Society _____ Office Phone _____

RESERVATIONS FOR EVENTS AND MEETINGS

(*Reservation deadline is February 27, 1998.* Reservations accepted on a first-come, first-served basis)

	<u>Number Attending</u>	<u>Cost</u>
Friday, March 13, 1998		
8:00 a.m.-5:00 p.m. Caring for Colorado's Underserved Conference	_____	Free
5:45 p.m.-7:30 p.m. Caring for Colorado's Underserved Dinner	_____	Free
SATURDAY, MARCH 14, 1998		
12 :15 pm -1:45 pm Luncheon	_____	Free

HOTEL RESERVATIONS

Please use the hotel information below to make your reservations directly with the Denver Marriott Southeast. **The deadline for room reservations is February 27, 1998.**

MEETING REGISTRATION

Please submit a registration form by February 27, 1998, if you plan to attend this Interim Meeting. We're delighted to receive it by mail, fax, or phone. We can check you in more quickly and efficiently if you've preregistered, in addition to providing more accurate and therefore cost-saving guarantees for our food functions. Thanks!

MESSAGES

The hotel's phone number is 303-758-7000. (You may want to leave this number with someone.) If you need to be contacted, ask the hotel operator to transfer the call to the CMS registration desk or CMS office.

WHAT TO DO

Complete this entire form and return it to Colorado Medical Society, by mail to: PO Box 17550, Denver, CO 80217-0550, by phone to: 303-779-5455 or 1-800-654-5653 or by FAX to: 303-771-8657.

Hotel Reservation Information

**Denver Marriott Southeast
Colorado Medical Society
Interim Meeting
March 14-15, 1998**

Reservations for the Interim Meeting at the Denver Marriott Southeast must be made by **phone**. Please call **1-800-228-9290** or **303-291-3637**.

Ask for the Denver Marriott Southeast and **request the Colorado Medical Society rate:** single or double - \$72, plus 11.8% lodging tax. **The CMS room block will be held through February 27, 1998.** The Denver Marriott Southeast will guarantee neither space nor the group rate after that date.

Check in time is 3:00 p.m., check out is 12:00 noon. To avoid cancellation fees, reservations must be canceled before 4:00 p.m. on the day of arrival.

The Denver Marriott Southeast is a full-service hotel offering 725 deluxe guest rooms with non-smoking floors available. In addition to the standard amenities, Marriott offers complimentary coffee service in the lobby each morning, data ports in each room as well as a full-size ironing board and iron in each room.

Call: 800-228-9290

**Denver Marriott Southeast
6363 E. Hampden Avenue
Denver, CO 80222**



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GLENWOOD SPRINGS multispecialty clinic seeks BE-BC general Internist for busy practice. Beautiful setting in rural area. Reply by sending faxed CV to: Tim Burns, Administrator, Glenwood Medical Assoc, P.C., (970) 945-0253 or mail to: 1905 Blake Ave., Glenwood Springs, CO 81601.
02/1297

RURAL COLORADO – Seeking to employ 3 BC/BE Family Practitioners to work with a nurse practitioner. Salary augmented by productivity agreement, benefits, loan repayment. Practice is located 3 hours north-east of Denver with a service population of 6000. The town of Holyoke has a strong economy and offers a variety of activities and community events. Send CV to Sherry Kozero-Roth, Physician Services, Western Plains Health Network, 1801 16th Street, Greeley, CO 80631 or fax (970) 346-1060.
04/1197

BOULDER – Excellent opportunity for Board Certified MD in Urgent/Family/Occupational care. Reply to Medical Director, Meadows Medical Center, P.C., 4800 Baseline, D-106, Boulder, CO 80303-2643. (303) 499-4800.
04/1097

ORTHOPEDIC MEDICAL CONSULTANT needed in Denver Area for Medical Case Management of Workers' Compensation Claims. Must be Board Certified in Orthopedics with general medical knowledge. Part or Full time work available with U.S. Potal Service. Send CV and day time phone number to David Bachman M.D., Senior Area Medical Officer, 1745 Stout St. #600 Denver, CO 80029

LOCUMS: 2 dependable BC EM MDs, 4 and 19 yr exper, willing to absorb seasonal peaks, episodic vacancies, part or full time slots, CO licensed, long term potential. No management fees. 817-485-8866.
11/1197

◆ SITUATIONS WANTED

BOARD CERTIFIED ORTHOPEDIC SURGEON with 30 years of experience in general orthopedics, trauma, arthritis, pediatric orthopedics, sports medicine, joint replacement, spine, geriatric orthopedics, and hand, seeking 1 to 3 days a week in a family practice, mixed specialty or orthopedic office doing office orthopedics. Provide prompt care, pleasing orthopedic patients in your office setting. Reply to CMS, Box 3, P. O. Box 17550, Denver, CO 80217-0550
06/298

BOARD CERTIFIED OCCUPATIONAL PHYSICIAN, Metro Denver. Experience necessary for physician owned & managed practice. Competitive salary & benefits. FAX resume: 303-373-4501, call 373-4456
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03/0198

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Suzi_Shevell@cms.org.

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GAZE AT THE BEACH as you relax in our delux 2BR, 2 bath condo on Sanibel Island, off the Gulf Coast of Fla. Call for more info: 719-579-8440. 11/0797

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◆ MISCELLANEOUS

LARGE, HIGHLY REPUTABLE, FDA regulated Preventive Health Care Co. has made available a safe, non-toxic, very palatable, soluble fiber product under patent which clinical studies have proven to help lower total cholesterol, LDL, triglycerides, and raise HDL significantly. This part-time business allows you to ethically enhance your practice revenues. Call G. Wayne Moss, M.D., F.A.C.S., (303) 988-7020, 1-800-597-1562. 03/1297

SURPLUS SUPPLIES OR EQUIPMENT?

Project CURE will pick up your surplus medical equipment, supplies, and books to recycle to third world countries. Call Dave Sattler at (303) 727-9414 or Fax (303) 727-8397. 11/0198

◆ MISCELLANEOUS (Continued)

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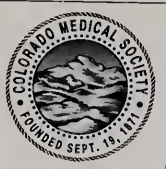
Call today for a free, no obligation consultation at your home or office.

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Attention Physicians: Did you know?

Tri-County Health Department, serving Adams, Arapahoe and Douglas Counties, provides free mammograms, breast exams, pelvic exams and Pap tests for qualifying, uninsured women ages 50 - 64. These services are made available through a cooperative program provided by the Colorado Women's Cancer Control Initiative, Tri-County Health Department, and the Susan G. Komen Breast Cancer Foundation.

You may request program materials for your office by calling Susan Moody, Cancer Screening Program Manager at 761-1340.



RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

The interminable march. . .

2000 and BEYOND

www.cms.org

"In the year 2000..." It was a catchy phrase, and it was futuristic sounding. It seemed futuristic to think about what would happen in the 21st century. But now we're looking toward the **near** future and the year 2000, less than 2 years away.

Just what all could this mean for medical practice? For the rest of us?

Our '96 CMS Annual Meeting was themed around medical practice in the future, and we were saying "**Medical Practice in the Year 2000 and beyond**," trying to prepare CMS physician-members for what future medical practice was going to be like. Since that meeting (a scant 15 months ago) practically everything on the healthcare landscape has changed, so how do you prepare anyone for anything?

On that date in '96 our keynote speaker was a medical futurist who talked about how technological trends and future components will

affect the individual practice of medicine and how the flow of information "is changing the face of the health care profession". The educational program was devoted to the development of information networks and "enterprise information integration." The objective of the educational program was to help you learn about the use of **Internet, Outcomes Analysis and Data Mining** in clinical practice. It was a course directed toward **better use of data by physicians - for physicians.**

And now it's time to put that training to work positioning yourselves for the next century.

On that date 15 months ago we were almost afraid to suggest "physician-specific data" or "outcomes analysis." Today we are awash in both, and they seem to be the only guide for the future of medical practice. That's not all bad, but the window of opportunity for **physicians to set the standards** on these new measurements is rapidly growing smaller and smaller. If "practice parameters" and "outcomes" are to be the measure by the "turn of the century," then there's just **TWO YEARS LEFT** for you to do it all!

15 months ago, we had just introduced the idea of the Colorado Medical Society going on the Internet, and we only did that three months later (December, '96).

Today, at CMS, it seems that the Internet is the principal communication tool for a growing percentage of physicians all over the country. "On line" is becoming a household term.

What is there to look forward to in 2000 (besides the 21st century)?

I'm not certain. I'm already confused just by the new terminology we'll have to use.

For instance: what will we call that time period? Can we refer to it as the "**Turn of the Century?**" For many decades we have been referring to the hoop-skirt era, the first of the horseless carriage era, the flip from the 19th to the 20th, as the "turn of the century"; do we now condition that phrase by saying "**the turn of the 20th to the 21st century?**"

And then, one of CMS' Division Directors, Sandy Finney, asked a while back: "Will we call these first years as the '20-hundreds' like we've been referring to the '19-hundreds?' And will we say '**in ought-ought**' like we say '**in '98?**'"

I can hear it now: "**The CMS Annual Meeting in two-thousand will be held....**", or "**The meeting in Two Oh-Oh-Oh....**".

I think the year "**Twenty-Oh-One**" will be easier (to say).

One good thing about this: everyone's in the same boat; no one has had any experience in 2000, so all that any of us can do is speculate about the 21st century.

NOTE: While we work toward that new century, we have put a constant reminder for you on the **CMS Web Page**. It's an interminable clock, ticking away the seconds until the year 2000. You can check it any time, day or night, to see just how much time (seconds, minutes, hours and days) you have remaining in the 20th Century. Colorado Medical Society is at www.cms.org.



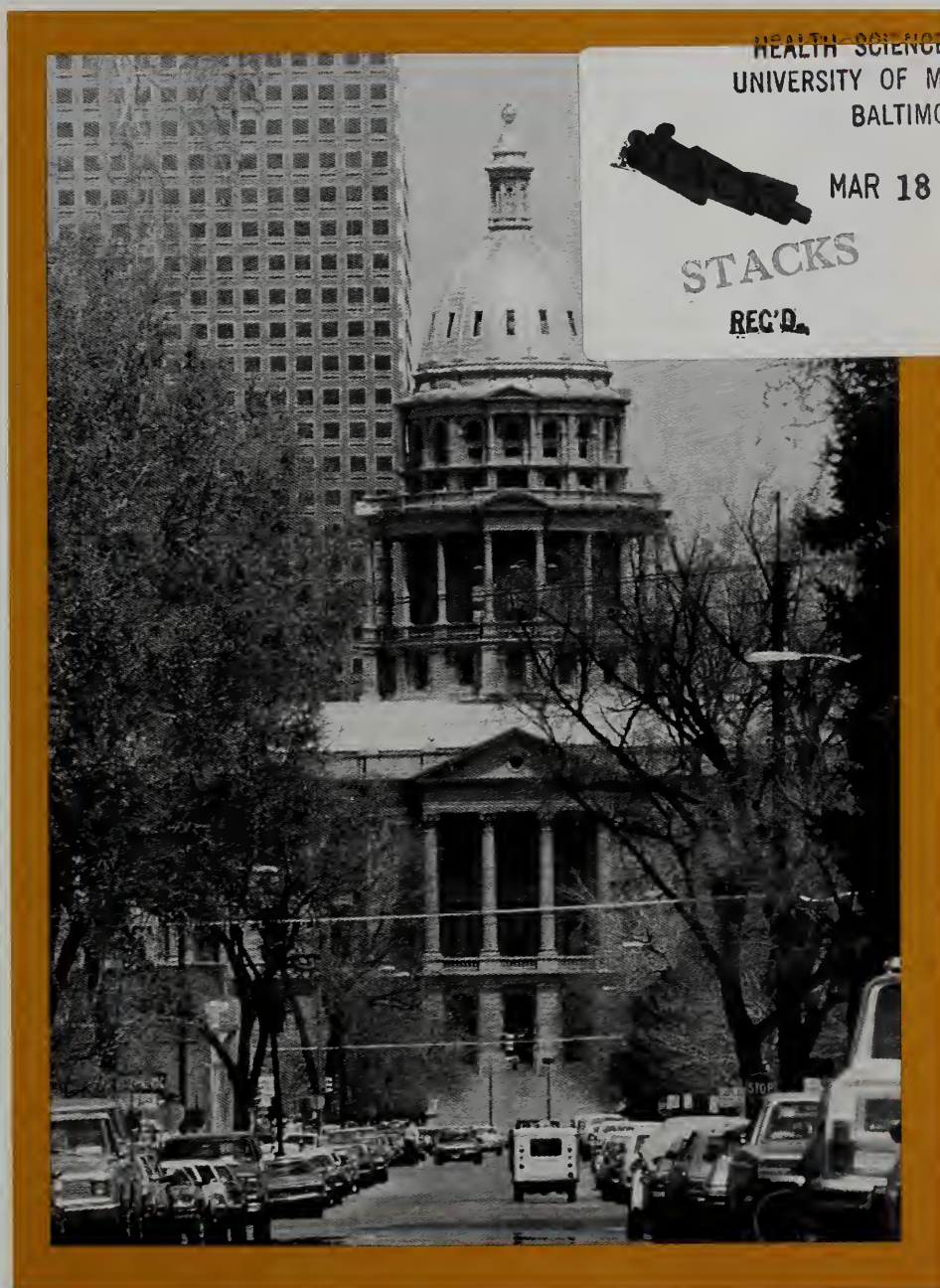
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1998

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Volume 95, Number 3



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Standout legislation of the year on Colorado's Capitol Hill. . .
(The Lobby - Pg. 76)

This Issue:

- The Slippery Slope of Professionalism** by Gary D. VanderArk, MD, President, CMS **page 75**
1997: Successes and Challenges by Richard D. Krugman, MD **page 80**
Surveillance & Follow-up of Brain Injury in Colorado by Gale Whiteneck, Ph.D. ... **page 82**
Pain Management: The emerging standard of care by Ben Rich, Ph.D., UCHSC **page 88**

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TURNING?
CHILLS?
STOMACH PAINS?

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COLORADO MEDICINE

March, 1998

Volume 95, Number 3



Cover Story

Some proposed health care legislation just attracts more controversy and takes more work than other bills.

HB 1205 is on top this year.
(See **THE LOBBY** - page 77.)

DEPARTMENTS

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In This Issue...

- 75 **The Slippery Slopes of Professionalism:** can we hang on to what we have? Can we avoid the slide that may well take us down in the professional ranks of caregivers? We have ascended; now we must maintain.
*by Gary D. VanderArk, MD
President, Colorado Medical Society*
- 78 **Guideline Development: A Collaborative Approach Can Work!** In the first statewide effort of its kind in the U.S., the **Colorado Coalition of Healthplans, Physicians, Hospitals, and other Providers** are working together to implement and evaluate evidence-based clinical guidelines.
By Diana Maier and Sandra DeSanto
- 80 **1997 filled with successes and challenges at CU School of Medicine.** It was an exciting year and, like many athletes say, the Dean says "I love this game."
*by Richard D. Krugman, MD, Dean
University of Colorado School of Medicine*
- 88 **Pain Management: The emerging standard of care.** As a result of recent surveys in the U. S. and Colorado, undertreatment of intractable pain is apparent. Attempted legislation has spurred health care providers to look more closely at pain management.
*By Dr. Ben Rich, Ass't. Professor,
University of Colorado Health Sciences Center
Assistant Director of the Program in
Health Care Ethics, Humanities and Law.*



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Gary D. VanderArk, MD
President, 1997-1998

Professionalism on the Slippery Slopes

All social phenomena tend to have three phases: ascension, maintenance and decline. We have seen the profession of medicine in its ascension. Where do you think medicine as a profession is today?

I think medicine as a profession is on a slippery slope. As a mountain climber, however, I've been on a lot of slippery slopes--sometimes going up and sometimes coming down. One of the crucial things about slippery slopes is that they need to be recognized, and another is that it's usually easier to go down than up.

Recall that I have said that a profession has three important characteristics; a distinctive knowledge base requiring special education, a vocation that serves others, and is self-regulating. I think our slippery slope has four components that are greasing the skid: division in the house of medicine, problems with professional autonomy, the development of medical management services and erosion in the physician-patient relationship.

The house of medicine is divided. We have divided on the basis of specialty, work setting, intellectual orientation, loyalties and role obligations. The house of medicine now consists of 70 subspecialties approved by the American Board of Medical Specialists (ABMS). Thirty-five of these specialties have been approved in the past decade. In the meanwhile, membership in the American Medical Association is shrinking. The AMA now represents about 40% of all physicians. There are now eleven different medical organizations in

Colorado that employ lobbyists.

There seems to be a growing rift between manager and managed, rule-setters and rule-followers, doctors as owners and doctors as employees, and between those who review and those who are reviewed. A key player in the new medical elite is the physician administrator. When a fellow physician takes a new administrative position with the hospital or other healthcare organization, we often joke about how long it will take them to transform from one of us to one of them.

A house divided cannot stand. Although autonomy is essential in my definition of a profession, it carries a high risk of corruption. Autonomy can lead to dysfunctional isolation. We have developed our sanctimonious myths about medicine's superior qualities and at times have patronizing attitudes. Our ability to convince the public that we are totally committed to service has faltered. We must never view as rights what has been entrusted to us as a privilege.

External organizations are corrupting our ability to be professional. Medicine was transformed in the 60s when the government introduced Medicare and Medicaid. As the largest provider of health care dollars, the government has intruded on our autonomy. Then came all manner of insurers--capped by the development of managed care organizations and capitation. If that were not enough, medical management organizations have taken over our practices and now there is a distressing tendency to even sell out to for-profit organizations.


"External organizations are corrupting our ability to be professional."

The physician-patient relationship is suffering. Patients will always assess the effectiveness of their care on the emotional support they receive from their physician. As physician employees have less and less time for their patients, the public will increasingly challenge the authority of the profession. At the same time, physicians burdened by increasingly complex rules, regulations and coding requirements will become frustrated at their ability to advocate for the patient.

So is there hope for the medical profession? What is CMS doing to provide a foothold on this slippery slope? I can hardly wait to tell you about it!

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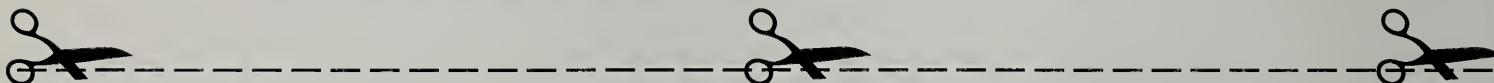
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CMS Med Fax[®]
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

HAC considers changes to Evaluation & Management Documentation Guidelines

At its January meeting, the CMS Health Affairs Council (HAC) was made aware of CMS member physicians' interests and concerns over the Health Care Financing Administration's (HCFA) Documentation Guidelines for Evaluation and Management (E & M) Services. In early February a letter was sent to all CMS members asking physicians for comments on these guidelines. HAC met again in February not only to review the immediate reaction to the call for comments, but also to consider what actions can be taken to encourage HCFA to re-think the intent, content and process of the implementation of these new requirements. This process will undoubtedly require long term grass-roots support by CMS and its members.

CMS recognizes that one of the underlying concerns surrounding the implementation of the documentation guidelines is the very real perception that the "guidelines" are in fact *requirements*, and will therefore become the principal auditing tool. For that reason the Colorado Medical Society encourages all physicians to not only provide input into revising the guidelines, but also to comply with the E & M guidelines. (If you did not have an opportunity to provide comments on the guidelines, or if you did not receive a copy from Medicare when they were distributed in November 1997, you can contact Marilyn Rissmiller at CMS on 779-5455 or 1-800-654-5653, ext. 2428.)

The issue of compliance will become increasingly important given the fact that more funding has been set aside for investigation and prosecution of health care waste, abuse and fraud. The issue of fraud and abuse will be explored at the president-elect's leadership conference in Vail on May 2-3, 1998. All CMS members are invited and encouraged to attend.

CMS also recognizes that the current guidelines and potential for prosecution may have a negative affect on both the patient-physician relationship and seniors' ability to access care. CMS has dedicated itself to finding an equitable resolution to member concerns about the E & M guidelines. HAC's plan of action will be presented to the CMS Board of Directors for approval this month and will subsequently be published in *Colorado Medicine*.

The Cancer Clinical Trials Task Force of Colorado

by Peter C. Raich, MD

Colorado physicians and patients have access to new cancer treatment approaches, investigational agents and cancer prevention, and control strategies, by participating in National Cancer Institute (NCI) approved clinical trials through the University of Colorado Cancer Center and the Colorado Cancer Research Program. However, nationwide it is estimated that only three to five percent of adult cancer patients participate in clinical trials. Many factors inhibit greater participation, including that the cost of care for patients on such clinical trials often are not covered by the patients' health plans. A recent survey of medical oncologists throughout the US indicated that 37 percent of respondents reported insurer denial of approval for participation in a clinical trial for at least one of the physician's patients, and 38 percent indicated that they

would place at least one additional patient on a clinical trial if the insurer were to cover the cost.

The Cancer Clinical Trials Task Force of Colorado was formed two years ago in order to find a non-legislative solution to the uncertainty of coverage by third party payers for cancer patients on clinical trials. The Task Force evolved from an initial meeting held in December 1994 with BlueCross/BlueShield officials and representatives of the Colorado Medical Society and the American Cancer Society. Shortly thereafter, a meeting with officials from the then FHP was also encouraging, and regular meetings have been held since, including, in addition to the above, representatives from the major Colorado health plans, as well as from the Rocky Mountain Oncology Society, the University of Colorado Cancer Center and the

(Continued on page 4)



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm
of Montgomery Little & McGrew, P.C.

*This column contains information concerning topics
of general interest in the medical-legal field. For further
information or help with specific problems, please
contact Montgomery Little & McGrew, P.C.*

The following article is reprinted with the kind permission of its author, Kerry A. Kearney, Esq., of Reed Smith Shaw & McClay, Pittsburgh, PA, who represents physicians, hospitals, medical device and drug manufacturers, and HMOs. Although the article refers to medical call centers, the principles apply to your medical practice as well.

Legal Liability and Risk Considerations for a Medical Call Center

By Kerry A. Kearney, Esq., Reed Smith Shaw & McClay
Pittsburgh, PA (412) 288-3046

Any review of recent health care newsletters shows that medical call centers are a "hot topic." Whether they are called Nurse-Triage lines, Demand Management call centers, or Nurse-On-Call centers, the thrust of the call center is fundamentally the same. Call centers operate 24 hours a day to give patients an opportunity to make informed and more cost effective health care choices. A registered nurse answers patient questions, guides the caller through urgent situations, discusses treatment options and otherwise answers patient questions.

Medical call centers attempt to reduce demand for health care by allowing patients to call a hotline 24-hours a day and speak to a trained nurse about symptoms. The goal of the medical call center is to reduce unneeded and expensive Emergency Room visits by providing educated on-the-spot phone advice to worried patients.

Insurers and employers are enthusiastic about call centers. Not everyone in the medical community is enthusiastic, however. Influential physicians have been critical of phone help lines. James Todd, M.D., executive vice president of the AMA has said: "More than anything else, 800 numbers are a way of saving money Nurses' education does not qualify them to give advice over the telephone without making a diagnosis. If someone has abdominal pain, it can be anything from gas to appendicitis.

How is the nurse on the other end of an 800 line going to advise someone about this and what is the advice based on?"¹

At the outset, there are several different types of medical call centers. The most common type is one in which an HMO managed care organization (MCO) or insurer offers a medical call center to participating patient insureds as a value-added service. Recent estimates suggest that approximately ten million Americans have access to membership-based 24-hour call centers. The thrust of these membership call centers is to provide triage -- in which a nurse helps a patient assess the seriousness of a medical complaint and the appropriate level of care. In addition to triage services for members of an insured group, there are community-based medical call centers in which membership is not a requirement. Non-membership call centers are set up by hospitals as a community service to engender patient goodwill in the hospital community and to assist participating doctors to reduce patients' unnecessary emergency calls. Although the hospital-based call center takes triage calls, it will also get calls for information, for physician referrals, for 911 emergencies, for information on chronic illnesses, and to schedule hospital and doctor appointments.

Although these non-triage community calls present special logistical, software and organizational challenges which any proposed community call center must address, the membership phone center and community centers face a common legal challenge in dealing with triage calls. How does the nurse at a physical distance from the patient avoid malpractice liability in helping the patient choose appropriate medical care when the nurse cannot see the patient and when a nurse is not trained to diagnose?

Despite the fact that more than ten million people now have access to medical call centers, research has found only one malpractice lawsuit involving advice provided by a nurse call center. In *Adams v. Kaiser Foundation Health Plan*, a nurse at a Kaiser call center, working without a written protocol, recommended that a six month old infant with a 104° fever be driven to a network hospital 55 minutes from home.² The parents drove part way and circled back to the nearest hospital emergency room. The infant suffered circulatory collapse and lost both hands and most of both legs. The family sued, alleging that the nurse's bad advice caused delay in treatment, which in turn caused circulatory collapse and loss of limbs. On February 2, 1995, a Fulton County jury found Kaiser negligent and awarded the family in excess of \$45,000,000 in damages. The case was settled under confidential terms pending appeal.

The *Adams* case was a defense lawyer's nightmare and illustrates many of the things a medical call center can and should do to reduce the risk of catastrophic damage awards. At the outset, the employee nurse had not been properly trained by Kaiser to handle phone-triage. Not only had she no guidance from Kaiser on how to

(Continued on following page)

handle triage calls, she was working without a written protocol or computer program to walk her through the health emergency. In addition, Kaiser had insufficient documentation protocols. What happened in the Adams call was hotly disputed. The jury believed the mother's version. Kaiser had no documentation to support the nurse's version of what took place on the call. The call was not tape recorded [consent to record is required] and there was no computer record of the questions asked and answered by the distraught mother. The mom testified at trial that the nurse "instructed" her to go to a distant hospital. There was no record to support the nurse's version that she merely discussed this as an option. Kaiser, as a large, for-profit corporation, was not a sympathetic defendant to a jury faced with a severely disabled infant.

Although one case does not suggest that there is enormous risk for telephone triage lines, there have been increases in the number of lawsuits filed against corporate health care providers like those who typically supply telephone triage lines. A review of the top ten jury awards of 1995, published in the March, 1996 issue of *For the Defense*, shows that six of the ten largest verdicts were against medical malpractice defendants and that four of those verdicts were against HMO providers. The six verdicts ranged from a high of \$98,600,000 to a low of \$45,000,000.

Despite these hefty awards, the liability risk of operating a triage call center can be managed by proper training, proper analysis of the risks, purchase of insurance and contract terms which allocate risk. Although there is no hard and fast set of rules for setting up a medical call center, experience suggests that there are at least ten rules which, if followed, will reduce the risk of liability for any entity proposing to operate a medical call center. Those rules are:

1. Telephone nursing is different from hospital or even clinic-based nursing. Most national call centers hire nurses with eight to ten years experience and then train for six additional weeks.
2. Medical Call Center nurses should tell callers the limitations of phone advice. Where a patient cannot be seen and where an unsophisticated patient caller may not know what to report, the nurse cannot provide complete advice.
3. Nurses must work from written protocols. Protocols

must reflect real medicine and not cost containment. They must be updated periodically.

4. The Medical Call Center should document the case and any options discussed. Medical Call Center supervisors should assure quality by monitoring calls and reviewing documentation. Taping requires consent.
5. Patient calls and records must be kept confidential. Confidentiality obligations vary from state to state.
6. The Medical Call Center should provide options, not advice, to the patient. A nurse cannot diagnose. A nurse should never "instruct" a patient he/she cannot see.
7. The Medical Call Center should describe the limitations of phone advice in plan booklets given to patients, employers and subscribers.
8. The call center should consider adding to contract documents: (A) who must defend and indemnify it; (B) whether any parties to the contract agree to limitations on liability; (C) arbitration; (D) choice of law and choice of forum clauses; and the right of the call center to review subscriber documents sent to patients.
9. The Medical Call Center should have insurance and should provide insurance to its nurses. Even if a case is dismissed, counsel will need to be hired.
10. Providers must keep abreast of changing law. Callers may be from different states. Different callers will have different rights to sue. Calls from out of state patients may result in lawsuits in distant states. State laws may impose special obligations, e.s., to report suspected child abuse or to keep AIDs or mental illness confidential.

Conclusion

Medical call centers are here to stay because empowered patients make wiser, more cost effective health care choices. Liability risks can be managed by setting up a call center with properly trained nurses who know the limitations of telephone health care and who stick to a script.

¹ In the 90s, "House Calls Are To Nurses, By Phone," New York Times, November 8, 1995, p. B7.

² Civ. Act. No. 93-VS79895E Fulton Co. Ga.

CMS Med Fax

(Continued from page 1)

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

**2nd Annual Conference on
"Caring for Colorado's Medically Underserved"**

Friday, March 13, 1998
Denver Marriott Southeast (I-25 at Hampden),
Denver, Colorado
(303) 779-5455 or 1-800-654-5653, ext. 2414

American Lung Association

17th Annual Big Sky Pulmonary & Critical Care Medicine Conference
March 25-28, 1998
Big Sky, Montana
(406) 442-6556

Fifth Annual Colorado Safety and Injury Prevention Conference

April 29, 30 and May 1
Breckenridge, CO Beaver Run Resort
(303) 861-6628

**Colorado Otolaryngology and Maxillofacial Society
Rocky Mountain Ear Round-Up**

July 23 - 24, 1998
Brown Palace Hotel
321 Seventeenth Street
Denver, CO 80202
Contact: Bob Conlon, MD or Debbie Brown, 970-484-8686

Send us your calender items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, have them send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include information detailing program sponsor, date, location and phone number for more information.

Colorado Cancer Research Program (CCRP), a consortium of nine front range community hospitals.

During the past two years the Task Force has provided information and education about the role of clinical trials in providing effective cancer treatment and answering clearly defined questions to guide future therapies. Specific NCI and FDA approved cancer treatment clinical trials are reviewed by a panel of community and academic cancer specialists. Three levels of information about these trials are provided or made available to the medical directors of the HMOs. The first is a concise "Fact Sheet", which summarizes the major treatment components in the trial, identifies potential benefits versus side effects and toxicities, if any additional costs are engendered, if any agents are provided free of cost, and a brief scientific evaluation. The second is the "Fast Facts", which is a two to four page summary of the salient portions of the clinical trial protocol. The third is the complete study protocol, which is available on request. This review process concentrates on those studies that are expected to have a sizeable accrual in Colorado, or where challenges have occurred or might be expected.

The establishment of this non-confrontational approach to increase coverage of patient care costs for patients on poor-reviewed Phase III cancer clinical trials was unique in 1995. Since then other efforts have been reported which extend coverage to certain populations on specific clinical trials. Also in 1996, the national BlueCross/BlueShield Plans agreed to provide its clients with access to pediatric cancer clinical trials through the two national childhood cancer cooperative study groups. In September of 1997, three adult cooperative groups sponsored by the NCI reached agreements with several health insurance plans in Wisconsin and Minnesota to cover care costs of patients on clinical trials through these cooperative groups.

The response to the Colorado program has been an enthusiastic endorsement by the health plan organizations and the providers, including financial support to the Task Force coordinating office located at the offices of the Colorado Cancer Research Program. The implementation of this program has been associated by fewer denials for clinical trials coverage, a heightened awareness of the crucial role of clinical trials in defining new treatment strategies, and an appreciation of the need to invest in present clinical trials in order to be able to set accepted standards for future therapies. We are in the process of assessing the program's impact with a participant questionnaire and with tracking of denials, impact of follow-up information, and ultimate outcome.

The author encourages any physician interested in the activities of the Task Force or wishing to relate difficulties with patient coverage for clinical trials to contact:

The Cancer Clinical Trials Task Force of Colorado
c/o Ms. Susan Reddy
Colorado Cancer Research Program (CCRP)
3955 East Exposition, Suite 104, Denver, CO 80209
Fax: 303-777-2642 Tel: 303-777-2663.
e-mail: ccrphp@aol.com

References:

1. Mortenson LE et al. The Impact of Managed Care on Oncology practice. *Oncology Issues* Sept/Oct. 22 - 27, 1997
2. Raich PC et al. Can HMOs be educated regarding cancer clinical trials?
J. Cancer Education Supplement to 12(3):96, 1997.

Additional Pediatric Immunization Considerations

Colorado Department of Public Health and Environment/Colorado Clinical Guidelines Collaborative

This Clinical Guideline is endorsed by Health Plans as a quality practice recommendation and is not intended as a description of benefits. Not all immunizations, even when delivered according to approved indications, are benefits of all participating Health Plans (e.g., travel-related immunizations, hepatitis A vaccine when immune globulin is suitable, influenza vaccine for healthy persons).

Achieving a High Level of Immunization: At every visit, a prominently displayed immunization record should be reviewed, and routine or catch-up immunization should be carried out. Mild illness should not be considered a contraindication to immunization^{1,2}, and is not associated with reduced seroconversion or with increased adverse events in studies of MMR vaccine³. There are few absolute contraindications to immunization and all children should be immunized with rare exceptions. **The following table summarizes vaccine contraindications⁶.**

Condition	Contraindication to	
	Live Vaccines	Inactivated Vaccines
Severe allergy to vaccine component	Yes	Yes
Moderate to severe illness (with or without fever)	Yes	Yes
Encephalopathy	—	Yes*
Pregnancy	Yes†	No‡
Immunosuppression	Yes	No
Recent blood product	Yes	No

*Applies only to pertussis vaccine. †Except OPV, in certain situations. ‡Except influenza during 1st trimester

Recording and Reporting of Immunizations: Health plans have increasing requirements for tracking immunizations. Regardless of other reasons for an office visit, it is important to notify the Health Plan or other tracking system of an immunization on a claim or encounter form. **This will reduce the number of office chart audits** which Health Plans are required to perform, assist in tracking unimmunized children and help lay the groundwork for efforts to update and complete the Colorado Department of Public Health and Environment's Immunization Tracking System. Providers may check this tracking system to investigate a patient's immunization history at (303) 692-2700 ext2701. It is recommended that practitioners report to their local or state immunization tracking system. All immunizations must be fully documented in the chart including an initialed administration note.

To be indemnified by the National Vaccine Injury Compensation Program (VICP), the following information is required on the permanent medical record:

- 1) The Vaccine Immunization Statement (VIS) given to the person who brought the child in for immunization. The appropriate VIS must be given and recorded every time one of the following vaccines is given: measles, mumps, rubella, poliovirus, diphtheria, tetanus, pertussis, hepatitis B, haemophilus influenzae b, and varicella.
- 2) The date of administration of the vaccine.
- 3) The manufacturer and lot number of the vaccine.
- 4) The name and business address (where the records are kept) of the health care provider administering the vaccine.

PLEASE SEE IMMUNIZATION RECORD SHEET ON BACK

Other Vaccines to Consider

Influenza⁴:

PRIMARY TARGET POPULATION: Children and adolescents who:

- have chronic disorders of the pulmonary or cardiovascular systems, including asthma;
- have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications);
- are receiving long-term aspirin therapy and may be at risk of Reye's syndrome after influenza;
- are household members of persons in high-risk groups or residents of chronic care facilities

GENERAL POPULATION: Physicians should administer influenza vaccine to any person who wishes to reduce the likelihood of becoming ill with influenza.

SIMULTANEOUS ADMINISTRATION OF OTHER VACCINES: Children and adolescents at high risk for influenza complications can receive influenza vaccine at the same time they receive other routine vaccinations.

Pneumococcal Vaccine⁵:

PRIMARY TARGET POPULATION: Children ≥ 2 years old with chronic illnesses that are associated with a high risk of getting serious pneumococcal infections or its complications, including children with:

- splenic absence
- sickle cell disease
- nephrotic syndrome
- CSF leaks
- immunosuppression, including asymptomatic or symptomatic HIV infection

FOOTNOTES

- 1) Centers for Disease Control and Prevention. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Morb Mortal Wkly Rep. 1994;43(RR-1):26.
- 2) American Academy of Pediatrics. Active immunization. In: Peter G, ed. Report of the Committee on Infectious Diseases. Elk Grove Village, Ill: American Academy of Pediatrics; 1994;35.
- 3) King GE, Markowitz LE, Heath J, et al. Antibody response to measles-mumps-rubella vaccine of children with mild illness at the time of vaccination. JAMA 1996;275(9):704-707.

- 4) Centers for Disease Control and Prevention. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Morb Mortal Wkly Rep. 1997;46(RR-9):5-9
- 5) Centers for Disease Control and Prevention. Epidemiology & Prevention of Vaccine-Preventable Diseases. 1997;4:244-245
- 6) Centers for Disease Control and Prevention. Epidemiology & Prevention of Vaccine-Preventable Diseases. 1996: 26-2

Immunization Record Sheet

Colorado Department of Public Health and Environment/
Colorado Clinical Guidelines Collaborative

Name _____ DOB _____ Parent _____

Address/City/ZIP _____ Phone _____

Medical History _____

Vaccine	Vaccine Brand	Immun. Date	Site/Dose	Manufacturer/ Lot Number	Form & Date *	Administered By (Name/Title)
HBV-1						
HBV-2						
HBV-3						
DTaP/DTP/DT-1						
DTaP/DTP/DT-2						
DTaP/DTP/DT-3						
DTaP/DTP/DT-4						
DTaP/DTP/DT-5						
Hib-1						
Hib-2						
Hib-3						
Hib-4						
IPV/OPV-1						
IPV/OPV-2						
IPV/OPV-3						
IPV/OPV-4						
MMR-1						
MMR-2						
Var-1						
Var-2						
Td-1						
Td-2						
Td-3						
Influenza/ Pneumococcal						

*Form and Date = Type and date of
Vaccine Information Statement
given to parent e.g., DTP 9/13/96

Children Beginning Immunization in Infancy											
Vaccine	Age	Birth	1 Month	2 Months	4 Months	6 Months	12 Months	15 Months	18 Months	4-6 Years	11-12 Years
Hepatitis B ^{1,2}		Hep B-1									
Diphtheria, Tetanus, Pertussis ⁴				DTaP or DTP	DTaP or DTP	DTaP or DTP		DTaP or DTP ⁴		DTaP or DTP	Hep B ³
H. influenzae type b ⁵				Hib	Hib	Hib ⁵	Hib ⁵				
Polio ⁶				Polio ⁶	Polio	Polio ⁶				Polio	
Measles, Mumps, Rubella ⁷							MMR			MMR ⁷	MMR ⁷
Vaccella ⁸							Var				Var ⁸

Summary of ACIP/AAP/AAFP Pediatric Immunization Recommendations

Colorado Department of Public Health and Environment/Colorado Clinical Guidelines Collaborative

Children Beginning Immunization In Infancy

Vaccines¹ are listed under the routinely recommended ages. [Bars] indicate range of acceptable ages for vaccination. Catch-up immunization should be done during any visit when feasible. Broken border ovals indicate vaccines to be assessed and given if necessary during the early adolescent visit.

Vaccine ▼	Age ►	Birth	1 Month	2 Months	4 Months	6 Months	12 Months	15 Months	18 Months	4-6 Years	11-12 Years	14-16 Years
Hepatitis B ^{2,3}		Hep B-1				Hep B-3					Hep B ³	
Diphtheria, Tetanus, Pertussis ⁴				DTaP or DTP	DTaP or DTP	DTaP or DTP		DTaP or DTP ⁴		DTaP or DTP		
<i>H. influenzae</i> type b ⁵				Hib	Hib	Hib ⁵						
Polio ⁶				Polio ⁶	Polio	Polio ⁶				Polio		
Measles, Mumps, Rubella ⁷							MMR			MMR ⁷	MMR ⁷	
Varicella ⁸							Var				Var ⁸	

PLEASE SEE NOTES ON BACK

Accelerated Schedule For Infants And Children Under 7 Years Old Who Start The Series Late*

Visit	Vaccine doses
1st visit (at least 4 months of age)	DTaP/DTP #1, Polio #1, Hib ^a , MMR (as soon as child is 12 months), HB #1
4-8 weeks after 1st visit	DTaP/DTP #2, Polio #2, Hib ^a , HB #2
4-8 weeks after 2nd visit	DTaP/DTP #3, Polio #3, Hib ^a
6 months after 3rd visit	DTaP/DTP #4, Hib ^a , HB #3
Age 4-6 years (before school entry)	DTaP/DTP #5 ^b , Polio #4 ^b , MMR #2 (at least 1 month after MMR #1)
Age 11-16 years	Td
a. Immunologically normal children age 5 years and older do not need Hib vaccine. If infant starts series at age 7-11 months, give 2 doses 2 months apart and booster dose at 12-15 months. If infant starts at age 12-14 months, give 1st dose. Give 2nd (and last) dose at least 2 months later. If child starts at age 15 months to 4 years, give just one dose.	
b. The USPHS and the AAP consider DTaP/DTP #5 and Polio #4 necessary unless the DTaP/DTP #4 and Polio #3 were given after the 4th birthday.	
* If child was born on or after 11-22-91, initiate the hepatitis B vaccine series.	

Children Beginning Immunization At Age 7 Years Or Older

Visit	Vaccine doses
1st visit	Td #1, Polio #1, MMR #1, HB #1
4-8 weeks after 1st visit	Td #2, Polio #2, HB #2
6 months after 2nd visit	Td #3, Polio #3, HB #3
10 years after 3rd Td	Td
At age 11-12 years	MMR #2 (at least 1 month after MMR #1)

Minimum Intervals Between Vaccine Doses

Vaccine	Dose 1-2	Dose 2-3	Dose 3-4
DTaP/DTaP (DT)	4 Weeks	4 Weeks	4 Weeks
Comb. DTP-Hib	1 Month	1 Month	6 Months
Hib			
HbOC	1 Month	1 Month	
PRP-T	1 Month	1 Month	
PRP-OMP	1 Month		
* Hib booster dose should be administered no earlier than 12 months of age and at least 2 months after the previous dose of Hib vaccine.			
Vaccine	Dose 1-2	Dose 2-3	Dose 3-4
Polio*	4 Weeks	4 Weeks	4 Weeks
* Sequential IPV/OPV, all-OPV, or all-IPV.			
MMR	1 Month		
Hepatitis B	1 Month	2 Months**	
** This final dose is recommended at least 4 months after the first dose and no earlier than 6 months of age.			
Varicella		4 Weeks	

The above table shows the minimum intervals acceptable between doses of vaccine. All vaccines should be administered as close to the recommended schedule as possible in order to maximize the protection from vaccine. It is **not necessary to restart the series of any vaccine due to extended intervals between doses.**

1. This schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. Some combination vaccines are available and may be used whenever administration of all components of the vaccine is indicated. Providers should consult the manufacturer's package inserts for detailed recommendations.
2. **Infants born to HBsAg-negative mothers** should receive 2.5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SmithKline Beecham (SB) vaccine (Engerix-B®). The 2nd dose should be administered ≥ 1 mo after the 1st dose. The 3rd dose should be given at least 2 mos after the 2nd, but not before 6 mos of age.
- Infants born to HBsAg-positive mothers** should receive 0.5 mL hepatitis B immune globulin (HBIG) within 12 hrs of birth, and either 5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SB vaccine (Engerix-B®) at a separate site. The 2nd dose is recommended at 1–2 mos of age and the 3rd dose at 6 mos of age.
- Infants born to mothers whose HBsAg status is unknown** should receive either 5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SB vaccine (Engerix-B®) within 12 hrs of birth. The 2nd dose of vaccine is recommended at 1 mo of age and the 3rd dose at 6 mos of age. Blood should be drawn at the time of delivery to determine the mother's HBsAg status; if it is positive, the infant should receive HBIG as soon as possible (no later than 1 wk of age). The dosage and timing of subsequent vaccine doses should be based upon the mother's HBsAg status.
3. Children and adolescents who have not been vaccinated against hepatitis B in infancy may begin the series during any visit. Those who have not previously received 3 doses of hepatitis B vaccine should initiate or complete the series during the 11–12 year-old visit, and unvaccinated older adolescents should be vaccinated whenever possible. The 2nd dose should be administered at least 1 mo after the 1st dose, and the 3rd dose should be administered at least 4 mos after the 1st dose, and at least 2 mos after the 2nd dose.
4. DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received ≥ 1 dose of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DTaP. The 4th dose (DTP or DTaP) may be administered as early as 12 mos of age, provided 6 mos have elapsed since the 3rd dose, and if the child is unlikely to return at 15–18 mos of age. Td (tetanus and diphtheria toxoids) is recommended at 11–12 yrs of age if at least 5 yrs have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every 10 yrs.
5. Three H. *Influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB®/Merck) is administered at 2 and 4 mos of age, a dose at 6 mos is not required.
6. Two poliovirus vaccines are currently licensed in the US: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The following schedules are all acceptable by the ACIP, the AAP, and the AAFP. Parents and providers may choose among these options:
 - 1) 2 doses of IPV followed by 2 doses of OPV.
 - 2) 4 doses of IPV.
 - 3) 4 doses of OPV.

The ACIP recommends 2 doses of IPV at 2 and 4 mos of age followed by 2 doses of OPV at 12–18 mos and 4–6 yrs of age. IPV is the only poliovirus vaccine recommended for immunocompromised persons and their household contacts.
7. The 2nd dose of MMF is recommended routinely at 4–6 yrs of age, but may be administered during any visit, provided at least 1 mo has elapsed since receipt of the 1st dose, and that both doses are administered at or after 12 mos of age. Those who have not **previously** received the 2nd dose should complete the schedule no later than the 11–12 year visit.
8. Susceptible children may receive Varicella vaccine (Var) during any visit after the 1st birthday, and those who lack a reliable history of chickenpox should be vaccinated during the 11–12 year-old visit. Susceptible children ≥ 13 yrs of age should receive 2 doses, at least 1 mo apart.

Immunization Program Resources

General Immunization Questions: (303) 692-2794

Ordering Vaccines and Supplies:

Public Clinics: (303) 692-2650

Medicaid: (303) 692-2798

(303) 692-2799

Colorado Immunization Tracking System: (303) 692-2795

VFC Questions: (303) 692-2798

Hepatitis B Project: (303) 692-2673

Disease Reports: 1-800-866-2759

Family Healthline (Parent Information):

(303) 692-2229 (Denver metro area) or 1-800-688-7777



Colorado Department
of Public Health
and Environment

The

Colorado

Clinical

Guidelines

Collaborative

Background

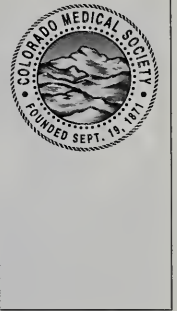
The Colorado Clinical Guidelines Collaborative was formed in 1996 to address the challenges for the use and implementation of clinical guidelines across health care systems in Colorado. Current membership represents 42 health care organizations.

Mission

A Colorado coalition of Healthplans, Physicians, Hospitals, and other Providers working together to improve health care through the development, implementation, and evaluation of evidence-based clinical guidelines.



Christopher Unrein, DO, Chairman
Council on Legislation



Each legislative year there is one piece of legislation that stands out, as we review and recommend positions on various proposals. This year's distinguished initiative is House Bill 1205. Seemingly simple, this act has spent a tremendous amount of legislative energy.

Here is how the bill looked at first. The original form had three major provisions: It would make hold-harmless clauses in managed care contracts illegal; it would attempt to close the loophole in the Federal ERISA laws that insulate managed care organizations from prosecution for denial of services (much like the now enjoined Texas law that recently passed); and the law could potentially pierce the corporate practice of medicine laws that have existed in Colorado since the 1960s case *Moon vs. Mercy Hospital*. That case established the Colorado law, that only physicians practice medicine - not entities. CMS's Board of Directors was strongly opposed to the threat to the corporate practice provisions, and charged the staff to work hard to change it. CMS worked with the bill sponsor, Rep. Martha Kreutz, to amend HB1205. The amended version of the bill strikes the corporate practice provisions; and, adds language requiring the medical directors of HMOs, making decisions on patients residing in Colorado, to possess a Colorado license to practice medicine. The amended

bill passed out of the HEWI Committee on a 6 to 5 vote, and has an uncertain future in the appropriations committee, or, if it gets that far, the floor of the house.

By the time it passed out of this committee, the rumor mill had been rampant. I received several phone calls both for and against. These sources also reported several versions of CMS's involvement in the bill. Let me set the record straight. CMS did NOT write this bill. CMS and its leadership is strongly protective of the physician's role in this sea of health care change. It would have been difficult to support this bill had the corporate practice language remained. This bill may end up contested in the courts, as the Texas bill did, despite its amended form.

So why should we spend so much time on it, if it won't become law because of injunction? There are several reasons. The bill's sponsor is a legislator who has been sympathetic to our issues, and we to hers. Through her efforts, we were able to execute the aforementioned amendments. Right or wrong, HMO bashing is in style. In that vein, this bill is seen as a patient's rights bill. How can the physicians of Colorado be against that? Finally, there is the issue of turf. The physicians against this bill were, in some form or another, medical directors of HMOs/IPAs. CMS is a democratic organization. On the Legislative Council, we do look out for our patients and the will of the majority (i.e., we have a house of delegates that is the policy-making body of our organization). Unfortunately, this does alienate some minority position groups.

"The house of medicine has been divided by too many factions . . ."

In closing, threatening (or worse, actually acting on the threat) to leave CMS only serves to continue a process that has allowed health care finance to become as chaotic as it is today. A house divided can not stand. The house of medicine has been divided by too many factions in the past. Let us "agree to disagree" and speak with one strong voice in order to recover what has been lost, and in order to preserve what is left of the practice of medicine.



Guideline Development: A Collaborative Approach Can Work!

by Diana Maier, Chair, Colorado Clinical Guidelines Collaborative, and Sandra DeSanto, Co-Chair, Implementation Work Group.

"This is the first state-wide effort of its kind in the U.S. . . ."

A SPECIAL PULL-OUT INSERT accompanies this article:

"IMMUNIZATION GUIDELINES"

Please remove and keep it for your office reference.

AUTHOR'S NOTE:

We would like to acknowledge the Colorado Clinical Guidelines Collaborative Work Groups of Pediatric Immunization and Implementation, and CMC (the Colorado Foundation for Medical Care) for their input and assistance.

It's Monday morning, a full schedule of patients await you and you have two stacks of mail to sort through. In one stack is a pediatric immunization schedule from one of the many health plans in which you participate. And in the other, a set of immunization recommendations from another health plan. Who has the time to compare and review these guidelines?

Faced with the challenges of developing and implementing clinical guidelines in an ambulatory primary health care provider system, Diana Maier of Exempla Medical Group (then Primera Healthcare) realized she had identified an improvement opportunity. Envisioning a better way, Diana believed that provider groups and health plans could come together to address the issue of multiple guidelines for the same health conditions. To promote the idea, Diana first visited with the Medical Directors of large health plans in Denver and Colorado Springs. There she discussed the possibility of coordinating efforts. The response was positive.

With the support of Primera's Chief Medical Officer, Dr. Eric Book, the concept was then presented to the Colorado Association of Managed Care Medical Directors in August, 1996. The association agreed with the proposal and on October 1, 1996 Primera Healthcare hosted and coordinated the first Clinical Guidelines Forum. With representation from 20 organizations, the forum participants created a coalition called the Colorado Clinical Guidelines Collaborative. The Collaborative first met in

November, 1996.

In its mission statement the Collaborative identifies itself as *A Colorado coalition of Healthplans, Physicians, Hospitals, and other Providers working together to improve health care through the development, implementation, and evaluation of evidence-based clinical guidelines.*

Today 42 organizations participate in the Collaborative. This is the first state-wide effort of its kind in the U.S., and it has achieved national recognition. A workshop about the Collaborative was presented at the Ninth National Forum on Quality Improvement in Health Care in December, 1997. An article about the Collaborative was published in the *Report on Medical Guidelines and Outcomes Research* on January 22, 1998.

The Collaborative is currently developing a formal organizational structure as a 501(c)3 non-profit entity and is seeking funding to further its mission. Strong administrative support and funds to promote and disseminate the guidelines are essential. The Collaborative is working to reduce the number of different guidelines received by physicians, and is obtaining endorsement from health plans to minimize disruption, duplication, and confusion.

The Colorado Clinical Guidelines Collaborative chose two guidelines for development in 1997: Adult Diabetes and Pediatric Immunizations. (This article addresses the Pediatric Immunization Guideline. Look for the Adult Diabetes guideline (Continued next page)

Guideline Development

(Continued from previous page)

in the next issue.) In developing the pediatric guidelines, the Colorado Clinical Guidelines Collaborative involved representatives from health plans, primary and specialty care provider organizations, the public health sector, and others.

The Colorado Clinical Guidelines Collaborative and the Colorado Department of Public Health and Environment's Immunization Program jointly developed the **Pediatric Immunization Guidelines** (see pull-out insert.) Bridging the gap between public and private health issues was not the intent of the Pediatric Guideline Development Work Group, but became an added benefit of the collaborative effort.

The Pediatric Immunization Guidelines incorporate the most recent (1998) recommendations from the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Practice. The following table lists

the notable changes for 1998.

Changes to Pediatric Immunizations Schedule for 1998*

- **Dose three in the polio series is recommended as early as 6 months of age.**
- **The second dose of MMR is now routinely recommended at 4-6 years of age.**

** Refer to the immunization schedule for more information.*

New and unique to the immunization schedule is a section entitled "Additional Pediatric Immunization Considerations" to support clinical decision-making at the practice site level. The Pediatric Immunization Guideline Work Group recommended that the Colorado Department of Health and Environment immunization schedule include information specific to physicians providing direct patient care. This section supports efforts to immunize during minor illnesses, explain contraindications, and other vaccines to be considered.

The Collaborative's participating organizations fully support this new Pediatric Immunization Guideline and have accepted it as the foundation for clinical improvement, audit, and regulatory purposes. It is the Collaborative's hope that the immunization guidelines will be used by all providers of pediatric care in the State of Colorado. The Collaborative is confident that this and other guidelines it develops will improve clinical outcomes, minimize duplication, and help providers deliver the best possible care to patients.

The Pediatric Immunization Guideline is the first in a coordinated statewide effort to support Colorado health care providers and patients with a single set of clinical guidelines that are easy to use.

For more information about the Collaborative and to access future guidelines and patient education materials, please visit the Colorado Medical Society's web page at www.cms.org and COPIC's web page at www.copic.com after March 1, 1998.

CALL FOR NOMINATIONS

1998 Wyeth-Ayerst Physician Award for Community Service

The Colorado Medical Society is pleased to announce that once again the Society will be cooperating with Wyeth-Ayerst Laboratories in presenting the 1998 Physician Award for Community Service. This is an opportunity for you, CMS members, to honor one of your fellows who has contributed in an outstanding way to his or her community. The criteria are simple, as follows:

- The recipient must be a physician licensed within Colorado.
- The recipient must be living; no posthumous awards are permitted.
- The recipient may not have received this award previously.
- The recipient has completed an outstanding record of community service which reflects well on the physician.

Each nomination made must be accompanied by a personal data sheet describing the nominee's community work. Supporting documents (testimonial letters and statements, published data, etc.) should also accompany the nomination. None of the materials will be returned.

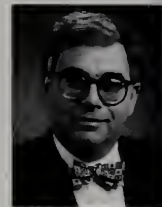
Nominations must be received by June 1, 1998. It is very important that **all nominations and supporting material be mailed to the following address:**

**Confidential Awards Committee
Colorado Medical Society
P. O. Box 17550
Denver, CO 80217-0550**



Successes, Challenges Summarize 1997 for School of Medicine

by Richard D. Krugman, MD
Dean, School of Medicine
University of Colorado



"1997 was a year marked by some impressive successes and some tough challenges for the University of Colorado School of Medicine."

I'd be less than honest if I didn't say that it personally was one of the most difficult years I can remember in my 24 years on the School's faculty.

First, though, the good news. Although the amount of tuition and state funding has remained fairly constant during the past 10 years, the continued growth in research grants, contracts and clinical earnings by our faculty have continued to be extraordinary. The hard work of this research and clinical faculty last year leveraged more than tenfold from our \$26 million state base and tuition to an overall budget for the School of right around \$300 million.

We have substantially more than double the average research income of all other public schools of medicine and substantially more clinical income as well. The CU School of Medicine also has proportionately less state support and tuition than other public medical schools, but that's a reality we've lived with for some time.

The impressive growth of contracts and revenues for our faculty practice plan, University Physicians, Inc. (UPI), in itself is a success story. The fact that the medical group practice evolved as it has is a testimonial not only to its leadership but the wisdom of its founders who decided that we should have a centralized plan. Many other medical schools around the country are struggling with their clinical enterprises and, in fact, are selling out their practice plans and/or their hospitals to outside entities.

Our primary care course, now in

its fourth year, has recruited 385 clinical faculty from the community who are involved in giving a half-day a week for three years to our students. The initial class that has gone through all four years with this change of curriculum will graduate this June. We'll see what the data are but whether more or fewer students go into primary care as a result of this experience is far less of an issue than the fact that, based on conversations with students, preceptors and our basic science faculty, the change was clearly for the better. When students have an opportunity to visit with and take care of families over three years, they develop an appreciation for issues like chronic disease, growth and development, or what is it like to be involved with death and dying.

For the first time in the 114 year history of the School, the majority of our entering class are women. It is certainly the case in a number of the clinical departments that a majority of our graduate medical education residents are women. At the same time, our under-represented minority student population is the lowest that it has been in quite some time. It's too soon to know whether this is a reflection of a national trend, but it is an area that I think both the state of Colorado and the nation need to be addressing.

Though the move of the School to the Fitzsimons campus is some years away, the School is actively participating in the planning process. A 2020 Research Vision Committee has set forth a goal for the School to strive to be in the top ten instead of

Successes, Challenges

(Continued)

the top 20 schools of medicine in research activity and excellence. That is a worthwhile goal. Space will be key in our efforts to continue to attract and retain our premier faculty and students.

Six years ago, we initiated a clinical strategy to focus on capturing patient populations rather than buying practices and hospitals, or selling ourselves out or leasing ourselves to others. That has been the correct strategy. Our goal at that time was to be providing coverage and care for 200,000 lives, and we've met that goal. Now it is time for us to address the next five years and potentially continue to assure access to populations that will become increasingly important if we are to continue our research and educational missions.

This past year, we faced some difficult challenges and decisions. The CU Board of Regents voted to abandon the Campus Center project,

which would have included an education building to meet the current needs of our students. The master planning process for the future move to Fitzsimons and the trepidation among the faculty about the move have been stressful to say the least.

University Hospital last year went through a significant downsizing and the impact on our clinical faculty and on those proving care in the hospital was substantial. Despite a long and positive history, we made the difficult decision to close our Med Tech program. Sustaining a baccalaureate program on a graduate campus was not something we could afford as we prepare to move into the next century.

It has been said that if academic medicine had discovered a way to provide quality care at less cost, we, rather than for-profit entities might have designed managed care rather than having to react to it. Legislators are also getting more involved in determining what the curriculum of schools of medicine should be.

California, for example, passed a law that says you no longer can get a license in the state unless you graduated from a medical school that requires four weeks of a family medicine clerkship. I don't think we can afford to get behind the curve in education the way we did in the clinical arena with managed care. We can't stand idly by and lose control of our curriculum. We need to be responsive to what we know that we need to do for our students and at the same time respond to what the public perceives we need. There are days when serving as dean of a School of Medicine is difficult, stressful and fatiguing, at best. There are other days when it is a joy. Fortunately, I am blessed with one of the most extraordinary and best faculties in the country, and it is an honor and privilege to serve them. I'll continue to do so as long as I can say truthfully at the end of the day what David Stern says for the National Basketball Association, and that is, "I love this game."

So Who's Got Money To Burn These Days.

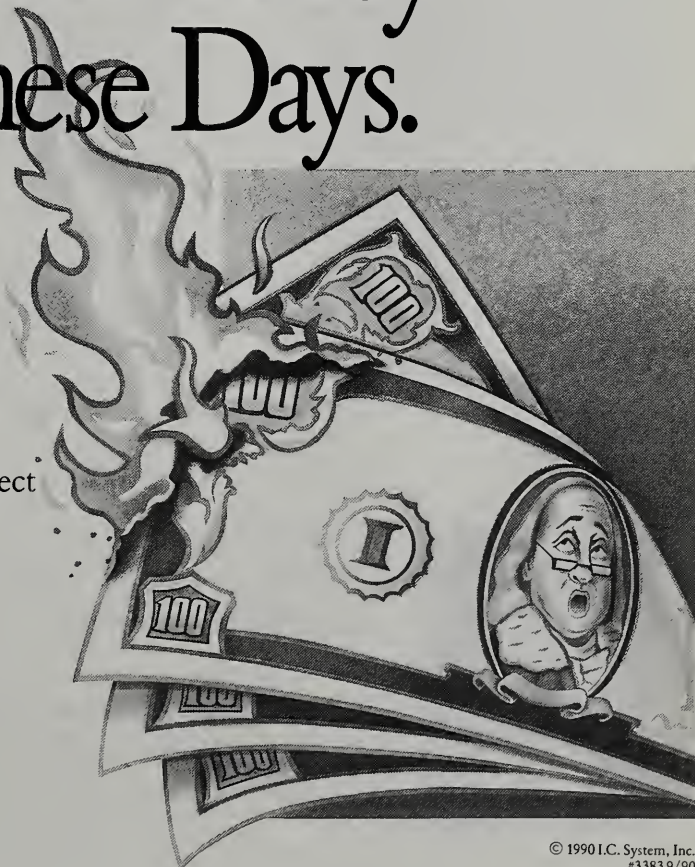
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Colorado Physician Network, Inc.



by David M. Martz, MD
President, CPN

Board of Directors Retreat

The CPN Board of Directors held a retreat attended by key leadership of Rocky Mountain HMO(RMHMO) on February 12th. All agreed that this was the most informative and productive meeting held in a long time. In addition to much of the CPN membership, the board members expressed frustration by the delay in Front Range enrollment. They were pleased to learn that RMHMO has been profitable in the last two quarters of 1997 after the financial setbacks of 1996, and that new staff has been added to implement Front Range marketing. Carl Naugle is the new director of Marketing, and he presented details of a revolutionary new insurance product with optimal choice which RMHMO plans to offer in the next 2-4 months. It is truly unique and is expected to give us the differentiation which we have been seeking--and at competitive premium rates. Details are currently proprietary and will be released in the weeks ahead.

Mark McCain, the Front Range Marketing coordinator, outlined the creation of a "SWAT Team" to ensure coordinated focused implementation in sequential communities along the Interstate 25 corridor over the next 6 months. Based on "readiness" strategies that include physician panel completeness, contracts with hospitals, and employer interest, we plan to attack each of several areas approximately every 2 months. The currently proposed sequence is Greeley-Fort Collins, Pueblo, and Colorado Springs, with options to modify as we go along based on response.

Meanwhile, lower key approaches will be taken in the Denver Metro region and the Eastern Plains rural communities. We will be quietly approaching some major Denver Metro large corporations (over 50 employees--where we expect the new product to have very strong appeal) in the weeks ahead, but an all-out attack awaits resolution of complex Medicaid issues which have been most costly in 1996-97. Likewise, RMHMO CEO Mike Weber reported impending

resolution of negotiations with the Colorado Division of Insurance which had heretofore prevented competitive premium pricing in the rural communities by RMHMO.

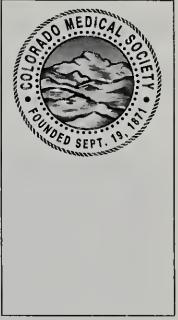
The board agreed that we must use additional communication techniques to keep our members better informed of the status of CPN, as much is happening that is of great importance and excitement. These may include special mailings, use of InterNet technology, and/or public meetings in your local communities.

In summary, despite disappointments that have slowed down our delivery of patients to you, we now have substantial reason to believe that Rocky Mountain Physicians Choice patients will be entering your practices in the months ahead. We already have about 5500 enrollees, and expect those numbers to grow significantly in the next 6 to 18 months as we proceed with the new product and focused marketing efforts. Stay tuned for further developments!



Dr. Malik Hasan, Chairman and CEO of Foundation Health Systems, will address the House of Delegates on Sunday, MARCH 15, 1998, at the CMS Interim Meeting.

Dr. Hasan will discuss what he calls the "Fourth Generation of Managed Care," a high-tech approach to delivering more rapid, direct and cost effective patient care in the future. Don't miss it!



by Gale Whiteneck, PhD
Richard Hoffman, MD, MPH
C. A. Brooks, MSHA
Barbara Gabella, MSPH

Surveillance and Follow-Up of Persons with Traumatic Brain Injury in Colorado

Introduction:

Craig Hospital is working collaboratively with the Colorado Department of Public Health and Environment and the Centers for Disease Control to design, implement and evaluate a statewide, population-based follow-up system for persons surviving traumatic brain injury (TBI). Approximately 1,300 persons will be selected each year from more than 3,000 adult Coloradans hospitalized with TBI to participate in this project. Acute care medical records will be reviewed and subjects will be asked to participate in an interview to determine health status, service utilization, quality of life and other long-term outcomes. This three-year project will produce not only a process for follow-up in the state of Colorado, but a model for other states, agencies and organizations.

The follow-up efforts of this project rely on the statewide TBI surveillance program, which has been in existence in Colorado since 1991. Each year, this program identifies over 3,000 new individuals who are hospitalized with, or die from, TBI in Colorado, an incidence rate of approximately 100 per 100,000 each year.

The follow-up system will include all adults who survived a severe TBI and a 20% random sample of adults with less severe injuries. The severe category will include all survivors transferred to in-patient rehabilitation programs and all survivors with an Abbreviated Injury Scale (AIS) score for the head of 3 or greater (typically indicating loss of consciousness of

more than 1 hour and/or sustaining a significant neurological deficit. Of the 3,216 hospitalized TBI cases in 1995, 2,924 persons survived. Among the survivors, 2,374 were age 16 years or older, of whom 933 were transferred to in-patient rehabilitation programs or had AIS scores for the head region of 3 or greater.

Methodology

The Colorado TBI follow-up system includes 2 methods of data collection: 1) retrospective medical record abstracting of the initial acute care hospitalization, and 2) prospective telephone interviewing of survivors as they cross anniversaries of injury. In addition to selecting cases for follow-up, the primary accomplishments of the project in its first year of operation have been the development and pilot testing of protocols, medical record abstracting, and follow-up survey instruments. These developmental stages of defining and testing the data collection variables for follow up have been conducted in cooperation with a national advisory board representing acute and rehabilitation providers, public health officials, TBI survivors and advocates, CDC staff, and researchers investigating outcomes after TBI. This diverse group of advisors assisted in identifying potential variables and instruments of interest in each of the following domains: general demographics, injury event, impairment measures, initial hospitalization, health status, disability, life status post injury, handicap, quality of life, post-injury changes and services utilization.

Colorado is the first state in the nation to receive a federal research grant to study... persons hospitalized with a traumatic brain injury (TBI) after they are discharged from acute care.

After weighing the strengths and weaknesses of many available options, variables were selected and the electronic abstracting forms and interview questionnaires were drafted. These were pilot tested, reviewed and modified, resulting in the current list of items included in the medical record abstract (Table 1) and the interview survey (Table 2).

Outcome Measurement Objectives

Driving the variable selection process are four objectives defined in consultation with the advisory board early in the project: 1) to determine the burden of disabilities (incidence/prevalence by selected groups), 2) to monitor trends in disabilities, 3) to identify subgroups of TBI cases at highest risk of disability, and 4) to determine service utilization and barriers. Specifically

(Continued)

ACCOUNTABILITY

(Continued from preceding page)

the project seeks to answer the following:

1. What are the outcomes and secondary conditions of persons with TBI identified in a statewide population based registry and prospectively followed over time?
2. What are differences in outcomes and secondary conditions in respect to: injury severity, etiology, demographics and pre-injury conditions?
3. What is the degree of change in major life status in outcomes pre and post TBI?
4. What patterns of service and resource utilization are associated with TBI?
5. What are the needs, gaps and barriers to service delivery and community integration for persons with TBI?
6. What methods are most effective and efficient in maximizing the success of follow-up contacts after TBI?

Summary

This study is currently in the main data collection phase, with medical record review and telephone interviewing underway. Persons, and their family members, who have sustained TBI in Colorado may soon be contacted and asked for an interview. The support of this major effort to systematically understand the outcomes and needs of persons hospitalized with TBI is encouraged. The staff of the Colorado TBI Surveillance and the Colorado Follow-Up System are committed to providing results of this research in future publications.

Address comments and questions to:
Gale Whiteneck, PhD
Craig Hospital
3425 South Clarkson Street
Englewood, CO 80110

Table 1: Acute Medical Record Abstract Variables*

Verification

- Admission date
- Discharge date

Eligibility

- Documented injury to the head
- Loss of consciousness
- Amnesia
- Skull fracture
- Neurological or neuropsychological abnormality
- Intracranial lesion

Radiological Results

- Type of Test - MRI or CT
- Findings

ICD-9 Codes

Patient Information

- Name, Address, Phone
- Birth date, Age, Sex
- Race, Ethnicity
- Marital Status

Circumstances of Injury

- Location
- Date, Time
- Etiology/Circumstances

Severity of Outcome

- Abbreviated Injury Scale Score (AIS)
- Injury Severity Score (ISS)
- Glasgow Outcome Scale
- Discharge Disposition
- Admission Glasgow Coma Score

High Risk Factors

- Alcohol/Drug Involvement

Miscellaneous

- Working at time of injury
- Previous TBI
- Previous alcohol/drug/neurological/psychological disorder
- Length of loss of consciousness
- Length of Post Traumatic Amnesia

*Table contains an overview of variables not a complete list

Table 2: Follow-up Interview*

Pre-Injury Health Status

Current Health Status

- Health Status questionnaire (HSQ-12)
- Symptoms Checklist

Productive Activity

Service Utilization

Cognitive Independence

- Cognitive Sub-scale of the Sickness Impact
- Profile (SIP)
- Cognitive Sub-scale of the Craig Handicap
- Assessment and Reporting Technique (CHART)

Physical Independence

- Sub-scale of the CHART

Mobility

- Sub-scale of the CHART
- Sub-scale of the Community Integration
- Questionnaire (CIQ)
- Questions from the Rehabilitation Services
- Administration (RSA) Community Reintegration Questionnaire

Spend Time With

- Sub-scale of the CHART
- Sub-scale of the CIQ

Transportation

- Sub-scale of the CHART

CAGE (Drug and Alcohol Assessment)

Economic self-sufficiency

- Sub-scale of the CHART

Functional Independence Measure (FIM)

Disability Rating Scale (DRS)

*Table contains an overview of areas and instruments included

"ACCOUNTABILITY"

is a regular monthly feature in

Colorado Medicine

Future articles will deal with

NCQA & HEDIS

"Outcomes for Dummies"

Collection and use of data

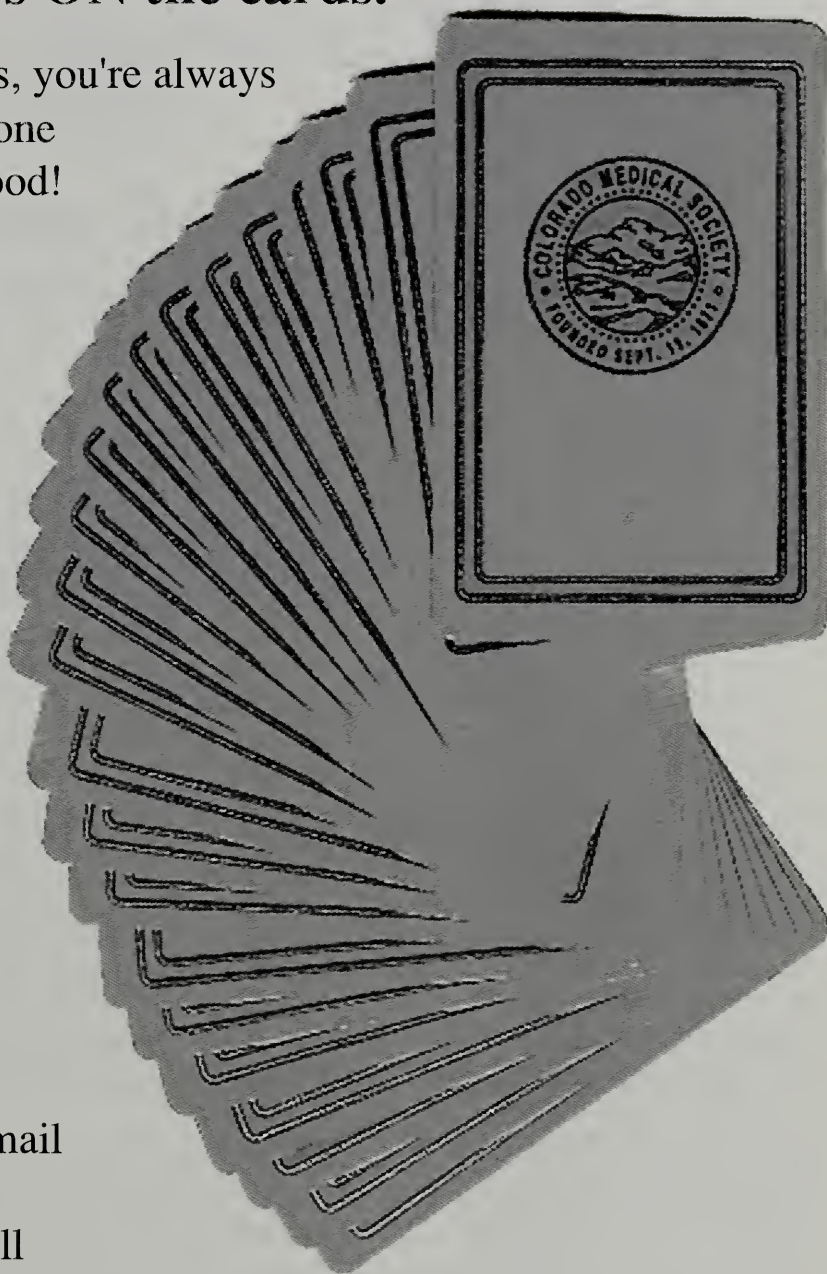
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Colorado Medicine for March, 1998



PSOs and Medicare Contracting: Education, Coverages, and Services to Help Copic-Insured Practices Succeed

Since the advent of managed care, many physicians have been searching for ways to regain the important decision-maker role they feel they've lost to the system with regard to the physician-patient relationship and medical treatment. Recent federal legislation promises to provide physicians with a means to recapture this role and regain lost revenues. Provisions of the Balanced Budget Act of 1997 will allow provider-sponsored organizations (PSOs) to contract directly with Medicare for the first time.

The provisions that will permit the implementation of so-called "Medicare+Choice" plans aren't just arcane regulations. They represent an essential alteration in the power structure of managed care, resulting in a system in which physicians may well be able to call the tune rather than just march to it. Known and trusted by their growing populations of Medicare-eligible patients, physicians will not only gain strength in their HMO contract negotiations but will also gain the capacity to compete head-to-head with health insurers for the lucrative Medicare Risk market.

It sounds like the solution everyone's been waiting for, but the potential benefits for physicians will carry a commensurate degree of risk. PSOs that contract with Medicare will be subject to strict licensing, solvency, and quality requirements.

Perhaps most importantly, contracts with Medicare will require PSOs to assume full financial risk on a prospective basis for providing the entire range of Medicare+Choice benefits. "The bottom line here is that PSOs that want to contract with Medicare will be 'bootstrapping' themselves into the most rigorously regulated managed care market in the world - and only the strong will make it into the program and survive."¹

To reap the greatest benefit from the new provisions with the least hazard, physicians in PSOs that wish to contract directly with Medicare will need an intensely sophisticated understanding of the myriad risks they and their PSOs are assuming. Copic offers education, coverages, and services to help you succeed in this new arena.

-- Contracts Seminar: It's often said that "the devil is in the details." There is arguably no instance in which this is more true than in contract negotiations. Beginning later this year, Copic will offer an ongoing educational program on contracting led by attorney Greg Ruland. The program offers a comprehensive review of contracting pitfalls and what to watch out for; of particular interest to PSOs seeking Medicare contracts are issues such as:

- What exactly are you agreeing to provide/do?

- How exactly will you/must you do it?
- How much risk are you taking? How will you mitigate it?

-- Capitation Stop-Loss Insurance: As part of the Medicare+Choice implementation, federal solvency requirements for PSOs are due out in interim final form April 1, 1998. These requirements will take into account the PSO's alternative means of protection - most notably, capitation stop-loss insurance. Copic Financial Service Group, Ltd. is available to assist you in securing this critical coverage at competitive rates.

-- Contract Review Service: Copic encourages all policyholders who are contemplating managed care contracts to consult legal counsel. On behalf of our policyholders, we have negotiated a reduced fee with the Law Offices of George D. Dikeou to review managed care contracts and provide a contract-specific assessment. Copic-insured practices can request this service by contacting Kathy Brown, Director of Business Development, at (303) 930-0490 or (800) 421-1834, ext. 2490.

Copic is committed to providing you with the tools you'll need to succeed in the changing healthcare landscape. I welcome your thoughts and suggestions about how we can best serve you.

¹Sokolov, Jacques J., M.D.; Gorman, John; Hannett, Fred; and Atkins, Larry, Ph.D. "Provider-Sponsored Organizations: A Sustainable Alternative to Medicare HMOs" Commissioned article submitted to Faulkner and Gray, August, 1997, for forthcoming book on Evolution in Managed Care Contracting.

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Colorado Medical Society

P

ain Management: The emerging standard of care

by Ben A. Rich, J.D., Ph.D.

"...what emerges is a compelling mandate that physicians acquire, maintain, and apply state-of-the-art pain management knowledge, skills and techniques."

Introduction: As a result of legislation proposed by Rep. Marcy Morrison in the 1997 Colorado General Assembly, which would have dealt with pain management by health care professionals, Copic Insurance Company created a task force to develop a seminar series on Pain Management. This series will commence in April, 1998. The author of this article, Dr. Ben Rich, Assistant Professor of the University of Colorado Health Sciences Center, is Assistant Director of the Program in Health Care Ethics, Humanities and Law.

The results of studies reported in the medical literature over the last 25 years indicate that all types of pain are inadequately managed in the United States (Marks and Sachar, 1973, Morgan, 1989, SUPPORT, 1995). A 1996 report by the Colorado General Assembly's Interdisciplinary Task Force on Intractable Pain (Interdisciplinary Task Force, 1996), as well as recent surveys at a number of Colorado hospitals (Fink, et al, 1994), indicate that the

undertreatment of pain is a problem for patients in Colorado as well. As the nature and extent of this problem have been elucidated, a number of state and national organizations have responded by promulgating clinical practice guidelines for the appropriate care of patients with acute, cancer, and chronic non-cancer pain (APS, 1993, AHCPR 1992, 1994, CBME, 1996). These guidelines may well have the effect of raising the prevailing standard of care, thereby creating an ethical, legal, and professional responsibility on the part of all physicians who care for patients with pain to acquaint themselves with, and bring their practice within the standards set by these guidelines.

The Colorado legislative task force and the Colorado Board of Medical Examiners, as well as organizations at the national level, have expressed the concern that many physicians continue to believe that they may be subject to close regulatory scrutiny, disciplinary action, and even civil or criminal liability, if they are diligent and persistent in their efforts to alleviate the pain of their patients through the use of opioid analgesics. In addition to an unfamiliarity with state-of-the-art pain management techniques, a lack of knowledge of the latest developments in the pharmacology of pain management, scientifically unsupported concerns about addiction and potential adverse side effects of opioid analgesics, and an inexplicable failure to make effective pain management a priority in patient care, these concerns consti-

tute some of the most frequently-cited barriers to the provision of appropriate pain relief to patients (Fink, et al, 1994).

In response to the growing awareness of and demand for an increase in the knowledge and proficiency of physicians in the assessment and management of all types of pain, COPIC has organized a series of CME programs on pain management throughout the State of Colorado, a number of which will be conducted in conjunction with hospital ethics committees. Physicians who attend one of these programs will be eligible for an adjustment of their COPIC professional liability premium.

It is important to note that in disposing of the issue of physician-assisted suicide, a majority of the justices of the United States Supreme Court took the position that there are no legal barriers that prevent physicians from providing appropriate pain relief to their patients. (Washington v. Glucksburg, 1997, Quill v. Vacco, 1997). This is the case even in the care of patients who are dying with pain that is so severe that efforts to relieve it may actually render the patient unconscious and hasten death. Some distinguished legal scholars have interpreted these opinions as recognizing a constitutional right of patients to effective pain relief (Burt, 1997). When considered in conjunction with the Colorado Board of Medical Examiners introduction to its pain management guidelines, wherein it "strongly urges physicians to view effective pain management as a high priority in all patients," so that "pain should

be assessed and treated promptly, effectively, and for as long as the pain persists," what emerges is a compelling mandate that physicians acquire, maintain, and apply state-of-the-art pain management knowledge, skills and techniques. This mandate is further bolstered by the ethical responsibility of physicians to relieve the pain and suffering of patients that is engendered by illness. The American Medical Association (AMA, 1997), the Institute of Medicine (IOM, 1997), and the American Board of Internal Medicine (ABIM, 1997), among many other national professional organizations, have all recently issued similar admonitions regarding the physician's professional duty, particularly with regard to patients who are at or near the end of life. The AMA, for example, states that among the elements of care that every patient should be able to expect from his or her physician is "trustworthy assurance that physical and mental suffering will be carefully attended to and comfort measures intently secured" (AMA, 1997).

The clear message from these distinguished national medical organizations is, as a matter of historical fact, not in any sense new or revolutionary in nature. An international panel of distinguished physicians, brought together under the auspices of the Hastings Center, identified four goals of medicine,

one of which is "the relief of pain and suffering caused by maladies." In the section of the report explaining this particular goal, the panel stated: "The relief of pain and suffering is among the most ancient duties of the physician and a traditional goal of medicine. For a number of reasons, however, contemporary medicine throughout the world often does not adequately meet that goal" (International Project, 1996). The undertreatment of pain in America, whatever its causes or explanations, has always been at variance with this age-old ethical admonition that the relief of pain and suffering due to illness is a fundamental goal of medicine. It is now readily apparent that the goals of medicine and the custom and practice of physicians can, with a concerted effort on the part of all practitioners, once more be congruent. In the words of the physician and medical ethicist Eric Cassell: "If a physician will take the relief of a particular patient's pain as a challenge--vowing at all costs to make that patient comfortable--the pursuit of that goal will lead to every other concept and action necessary for the relief of suffering" (Cassell, 1991).

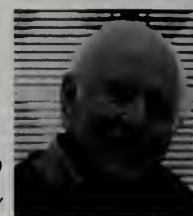
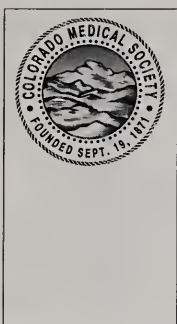
Accepting the challenge to make a patient comfortable, particularly when the disease has progressed beyond the efficacy of therapeutic interventions, is rapidly progressing from the status of an option to an

ethical and a legal obligation of the physician. Not so very long ago it may have seemed to be the case that a physician's only legal concern with regarding management of pain was not to be perceived by regulators as overly aggressive in offering opioid analgesic therapy to patients. But in 1991, a jury in North Carolina returned an award of \$7.5 million compensatory and \$7.5 million punitive damages against the operator of a long-term care facility. The operator and a nurse were accused of failure to provide a terminal cancer patient with the opioid analgesics that previously had been prescribed for him by a physician (Estate of Henry James). Significantly, the malpractice insurance carrier settled the case for an undisclosed amount without an appeal.

There are a number of lessons to be learned from such a case. First, a standard of care for pain management, particularly for patients with a terminal condition, can be established with a sufficient degree of certainty to support a malpractice claim. Second, a jury can be expected to hold health care professionals responsible for providing appropriate pain relief to patients. The more severe the patient's pain, the more likely it is that a jury will award substantial damages for a health care professional's failure to diligently pursue palliative measures.

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John Lightburn, MD
Historian, Colorado Medical Society

Medical entrepreneurs on the eastern plains.

On Sept. 3, 1935, the Cheyenne Wells newspaper printed in banner headlines the marking of a new era in medicine and surgery in eastern Colorado.* Dr. L. N. Myers, in collaboration with the Kit Carson County Medical Association, inaugurated the first Annual Surgical Clinics at the Cheyenne Wells Hospital on April 1 and 2. The paper reported "A score of physicians from western Kansas and Eastern Colorado and Denver were unanimous in their praise of Dr. Myers and his work at the local hospital. Starting at scratch, Dr. Myers had built an up-to-date, modern hospital substantiating his belief that rural communities should not lack the best in the care and preservation of human life. Honored guest of this unique clinic was Doctor Judson D. Moschelle, an eminent thyroid surgeon of the east who demonstrated a new method in goiter operations."

In its report on the first annual clinic, the local newspaper described Dr. Myers in glowing terms. Indeed, he was the local hero. He had received his medical education at Northwestern University and Cook County Hospital, studying under such notables as Carl Meyer, Max Thorek and Julius Spivot. Dedicated to the idea that modern care should be available to the rural populations, he first started practice in Aspen, Colorado; but Aspen was a dying mining town with no future! So in 1932 he moved to Cheyenne Wells where Dr. Kaufman had opened a hospital in 1920. As a business venture, it was a failure for Dr. Kaufman, so he was happy to turn it over to Dr. Myers when he

arrived in 1932. Dr. Myers began working for the renovation of the hospital. An energetic man, he also became mayor of the town in 1934. The newspaper reported "he only recently has brought about a chlorinating (chlorinating) of the drinking water which in his opinion will stamp out the prevalent high mortality rate desenttery (dysentery) which was exceeded by no other community in the United States." Not satisfied with a modernized hospital, he persuaded his colleagues in the Kit Carson Medical Association to bring to reality his dream of Annual Surgical Clinics.

The first "Clinic" was a tour de force for Dr. Myers as the following schedule demonstrates:

Monday, April 1st

9:00 A. M. Appendectomy
10:00 A. M. Inguinal Hernia
11:00 A. M. Hysterectomy
by L. N. Myers, M. D., and associates
1:00 P.M. Luncheon
2:30 P.M. Thyroidectomy, Goiter clinic and lecture
by Judson D. Moschelle, M.D.

6:00 P.M. Dinner and Smoker

Tuesday, April 2nd

9:00 A. M. Splenectomy
10:30 A. M. Radical Breast Amputation
11:30 A.M. Cholecystectomy
by L. N. Myers and assistants

The clinic was a great success with physicians from western Kansas, eastern Colorado and Denver attending. And the reopening of the remodeled Cheyenne County Hospital was a source of pride and delight for the citizens of Cheyenne Wells and for Dr. Myers.

The new \$2,000 Trane heating system and the \$5,000 x-ray installation was called the largest and best in the state. There were new Simmons beds and the most completely equipped laboratory between Salina, Kansas and Denver. What made this all such an amazing accomplishment was that it had taken place in 1935, in the depth of the "Great Depression" and in the midst of the worst drought in the history of the state. For three years, each spring had witnessed the wind blowing day after day, and huge, brown clouds of dust filling the sky, blotting out the sun and destroying the crops the already bankrupt farmers had planted. President Franklin Roosevelt was in the third year of his first term and the country, though more hopeful, had not yet recovered from the depression.

What boundless optimism and courage it must have taken to have raised the money, enlarged and modernized the hospital and put on the First Annual Surgical Clinic. There was no Medicare or Medicaid, no hospital or medical insurance; just farmers in debt and the banks foreclosing. Where was the money to come from? Was Myers a visionary or a fool?

Leonard Myers was not the only courageous leader or foolhardy adventurer in the area. Ninety miles northwest of Cheyenne Wells, there was a friendly but fiercely competitive colleague in the small town of Seibert. This was William L. McBride, M.D., and his is an interesting story. Dr. McBride was born in a small farm house near Formosa, Kansas, on October 19, 1885. There



William L. McBride, M.D. about 1925

was a severe rainstorm that day. His father, a teacher, farmer, carpenter and eventually a lawyer, finally settled in Mankato, Kansas, where William McBride grew up. He married Bessie Omer, a school teacher in Mankato, in 1908. They both taught school for two years in Oklahoma, saved their money and then moved to Kansas City where they both were admitted to the Kansas City College of Medicine and Surgery. Needing financial support, Bessie became a nurse and a very competent physicians' assistant. William received his M.D. degree in 1917.

Moving back to Mankato, they started practice in nearby Burr Oak, Kansas. After just a few months in Burr Oak, Dr. McBride and a friend, E. L. Nitter, M.D., decided to move to eastern Colorado where there was a need for physicians. Dr. Nitter started practice in Joes and Dr. McBride in Seibert. "Bessie and Bill" were a great pair and were welcomed by the town. They were pleased with their new community and enjoyed horseback riding in their leisure time. He loved horses so much that he frequently made house calls on horseback even though the automobile was a much more efficient form of travel. During the influenza epidemic of 1918, he wore

out his first "flivver" (Model T Ford) speeding in a cloud of dust from one patient to another. Winter snows that drifted over the highways made such trips difficult. On one occasion, Dr. McBride traveled by railroad hand car on the Rock Island track to Vorna where he hired a horse to travel through snow drifts to deliver a baby. As the practice grew, Dr. McBride recognized the need for a local hospital. Tragically losing patients made him even more determined to build a hospital. One such loss occurred one winter day when he was called to see a farmer, a man with a family of six children. He appeared to have acute appendicitis and urgently needed surgery. On a horse-drawn sled the sick man was transported to the railway station and transported to a Rock Island train to be taken to Denver. He died before reaching the operating table. McBride was convinced that he could have saved the man if he had had a hospital in Seibert.

In 1925, with his own money and a loan from the local bank, he converted an attractive, tree shaded homelike building on the main street into the Seibert Emergency Hospital. To prepare himself for his expanded practice, he went to Chicago where he participated in courses on

hospital, he installed an x-ray laboratory, the first one in the state east of Denver. Frequently consulting with surgeons in Denver who would advise him when he was over his head, he developed a very busy and successful practice with a loyal and dedicated hospital staff. He was a tough but fair boss, plain spoken and sometimes profane. He was the hospital superintendent, resident, intern, laboratory technician and attending physician. When practice was slow, he and Bessie would go riding together on their favorite horses. Or he would take his son fishing on the nearby Republican River. Whether playing or working, there was no time for inactivity.

Then came the drought and the depression of the 1930s. He continued to care for all who came, regardless of their financial condition. In January, 1933, another epidemic of influenza of unusual severity swept over the country creating a crushing burden on the McBrides. Exhausted, Bessie was infected and on January 30, 1933, she died with her grief stricken husband standing by helplessly as she took her last breath. Bessie and Bill had been married for 25 years and had worked together in Seibert for 17 years. The community had depended on them and loved them.

A tribute in the local newspaper described her as a "beautiful person... whose mission ... was a work of kindly ministration, a life spent in service and the promotion of love, harmony and happiness." William McBride has lost his right arm, his best friend and his lifelong sweetheart.

McBride's drive and dedication to his patients could not lie dormant for long, and he was soon working at his customary pace in spite of his grief, dust storms and the continued drought. He

arranged for care of his son and daughter, and after a few months began courting Zetah Straub, a widow from Flagler who was the Postmaster there. She had three



The Hotel Flagler, which became the Flagler Hospital, and then the Flagler Municipal Building.

surgical technique and antiseptic procedures. His mentor was Dr. Max Thorak. He taught his wife Bessie to be the anesthetist using open drop ether. Shortly after opening the



Flagler Hospital, as it was rescued from the defunct Flagler Hotel. Dr. McBride purchased the property and opened the hospital in 1937. It closed in 1962 after 25 years of caring.

children. Zeta and William were married in June, 1934. Although he had his hospital in Seibert, he was not satisfied. Dr. Leonard Myer had a better hospital in Cheyenne Wells; Drs. Courtney and Hays had started a hospital in Burlington; Dr. James Clanin had started a maternity hospital in Limon. Although the Kit Carson County Medical Association provided an opportunity for collegial camaraderie, there was a strong rivalry and McBride was not the sort to walk away from a contest. So, shortly after marrying this lovely woman from Flagler, an opportunity presented itself.

The Hotel Flagler, which had fallen victim to the hard times and dust storms, was for sale. It could be converted into a much better hospital than the one in Seibert. Amazingly, Flagler, with a population of less than 700, already had three practicing physicians: Harry L. Williams, M.D., O. S. Neff, M.D., and E. W. Reed, M.D. This did not deter McBride. He moved to Flagler, raised \$20,000 (a lot of money in those days) and created a fine hospital which opened in 1937. At the same time, his older stepson, John Straub, a medical student at the University of Colorado, married a beautiful young nurse on the staff of the Colorado Psychopathic Hospital.

After completing an internship and two years of surgical residency, John went off to war. After the war, he and his wife returned to Flagler where they joined Dr. McBride to create a family medical team. Continually consulting with specialists in Denver, this provided high quality medical for the community. There were 9,023 admissions and 2,200 births during the hospital's

25 years.

In 1951, Flagler sponsored an air show rather than a rodeo, as part of the Flagler Fall Festival. After a parade and barbecue in town, the large crowd gathered at the Flagler airport. A low-flying plane went out of control, crashing into the crowd, killing seven adults and thirteen children, and injuring many more. The hospital was overwhelmed and many had to be transferred to Burlington, Limon and Denver. Nevertheless, the hospital's proximity to the event saved lives, and the community was grateful it was there. In that same year, two months, later, the American Medical Association named Dr. McBride as "Doctor of the Year" at the Association's mid-winter meeting.

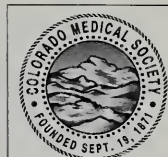
Dr. McBride had turned over the hospital to Dr. Straub in 1947 but remained active for several more years. After the air show tragedy, he became less involved, spending his summers in Yellowstone National Park. Following Dr. McBride's example, John Straub worked hard, but the hospital became too expensive to operate and, with the advice of his accountant, he made the painful decision to close the Flagler Hospital in 1962 after 25 years of operation. It was the last physician-owned hospital to operate in the

state. The building stood vacant for a time and then was occupied by a museum and municipal offices. In 1997 the old hospital building was placed on the National Register of Historic Places.

In contrast, Leonard Myers had sold the Cheyenne Wells hospital to the county in 1974 for \$100,000. The county then transferred ownership to The Sisters of St. Joseph for \$25,000. The hospital was renamed St. Joseph Hospital. Despite additional improvements, the hospital did not meet the Board of Health standards. So, with Hill-Burton funds paying 45%, the community paying 20%, and the Sisters paying 35%, a new hospital was built and was dedicated as St. Joseph Hospital of the Plains on October 27, 1963, one year after Dr. Straub had closed Dr. McBride's hospital in Flagler. But individual physicians still had an enormous impact. Dr. Jerome Keefe came to Cheyenne Wells in 1948 and served the community and the hospital for over forty years. In recognition of Dr. Keefe's contribution, the hospital was renamed Keefe Memorial Hospital, now a county hospital with revenues of over \$2,400,000.

There are many other rural hospitals with similar histories. In Colorado, there are 31 hospitals with a bed capacity with less than fifty. Those 31 small hospitals with a total capacity of 616 beds are a vital part of the state's health care system. In the future, this space will contain some more stories about those amazing institutions.

Note: Thanks go to members of the Flagler Historical Society and to Ms. Betty Talbert of the Cheyenne Wells Historical Society for their valuable help in supplying details.



In Memory

It is with regret that we report the death of Brent Lovejoy, DO, on Jan. 24, 1998, after a long illness.

Dr. Lovejoy specialized in occupational and sports medicine. He practiced in Englewood. He had been a member of the Colorado Medical Society since September, 1977, and was active in committee work a good portion of his membership. Dr. Lovejoy was most active on the Workers' Compensation Committee and a valued contributor to this committee's work and successes for several years.



Brent Lovejoy, DO

Kroger Receives Award

J. Stephen Kroger, MD, FACP, COLA's Chief Executive Officer, has been named Internist of the Year by the Colorado Society of Internal Medicine and the Colorado Chapter of the American College of Physicians. Dr. Kroger received the society's Laureate Award, and will be honored at a formal awards ceremony at an ASIM/ACP chapter meeting on February 5 - 7, 1998, at the Broadmoor Hotel in Colorado Springs, Colorado.



J. Stephen Kroger, MD

The Laureate Award symbolizes the formal recognition of individuals who have devoted their careers to the advancement of the profession of internal medicine, as well as promoting quality patient care. Dr. Kroger has been active in the American Society of Internal Medicine for the past 25 years. He served as an ASIM Trustee, President of the Colorado Society of Internal Medicine and Chairman of ASIM's Laboratories Committee. Currently Dr. Kroger serves as the Chief Executive Officer of COLA, a national non-profit healthcare accreditation organization. He was noted for his work in consulting with the Centers for Disease Control and Prevention toward implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA). He was also appointed to the CLIA Advisory Committee by the then-Secretary of Health and Human Services..

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Domestic violence is the leading cause of injury to American women. And in more than 50% of homes in which a woman is beaten, her children are also abused.

Together we can put an end to a terrible injustice. For more information, call the Colorado Coalition Against Domestic Violence at 303-831-9632.

Attention Physicians: Did you know?

Tri-County Health Department, serving Adams, Arapahoe and Douglas Counties, provides free mammograms, breast exams, pelvic exams and Pap tests for qualifying, uninsured women ages 50-64. These services are made available through a cooperative program provided by the Colorado Women's Cancer Control Initiative, Tri-County Health Department, and the Susan G. Komen Breast Cancer Foundation.

You may request program materials for your office by calling Susan Moody, Cancer Screening Program Manager at 761-1340.



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01/0298

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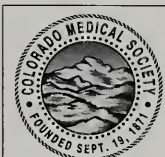
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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

It was April, 1961. I was in Washington, D. C., attending a White House briefing.

John F. Kennedy was the President. He invited publishers and news editors from all the U. S. to join him at the State Department for a "Presidential Briefing" on the Cuban invasion. The invitation described the event as a one-on-one "backgrounder" session with the President and State Department officials. Everything said was to be "off the record." In those days, that label meant that we were expected

to remain honor-bound and not print or broadcast what we were told. Today, that idea makes no sense at all, but back then the White House and the Presidency still held enough awe and honor that editors viewed both with especial esteem. I was in Washington often in those days because there seemed to be something of this nature happening frequently.

The White House knew that the administration was going to get a lot of heat for screwing up the Cuban situation. You may remember that the U. S. (it came out later) supported the military training of Cubans opposed to the Castro regime, and the U. S. was supposed to provide aerial support for these men who went ashore in this ill-fated attempt. The White House continually denied this, and was still publicly denying both stories in 1961.

So why invite the editors into the cradle of U. S. foreign policy and a face-to-face with Jack Kennedy? Obviously, it was an attempt to gain editorial support for the covert White House decisions made without authorization of Congress and the American public. In those days, it was Bobby Kennedy, the President's brother, who was the behind-the-scenes power and foreign affairs decision-maker. We swallowed it, hook, line and sinker because we still held the Presidency in respect and because he conditioned our discussion with "I am telling you this only on the condition that you will not publish the story, because it will endanger national security." There were NO leaks.

Why am I digging all this up

again? Because February, 1998, reminds me so much of 1961:

- President orders increase by nearly 3-fold the troops and weaponry in the Persian Gulf area.
- President makes a decision independent of Congress and public attitudes.
- President's cabinet members go on the road to sell the idea of U. S. air strikes on Iraq.
- President speaks to nation, warning citizens to prepare for war, in an attempt to explain his reasoning and gain support.
- President still not forthcoming about what has been happening in covert White House activities or the accusations made. What else don't we know?

President Bill Clinton doesn't have a brother in the administration to help him plan out these things, but he has plenty of other help.

President Kennedy stood before the publishers and editors, admitting U.S. support of troop training and the promise of air support for the Cuban invasion. None of this came out until years later, after John F. Kennedy and his brother, Bobby, were dead and gone. We kept their secret.

I'm not in on the national news scene any more, but I wonder how many secrets are still being kept, not just about male-female tete-a-tetes, and certainly not by news editors, but by White House and administration officials about other substantive national/international issues. I suppose that is something we will never know. It's happened to some degree in every administration.



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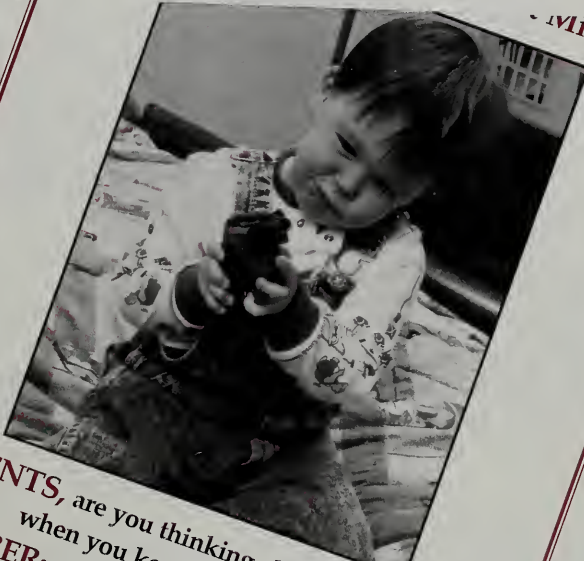
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Thank You!

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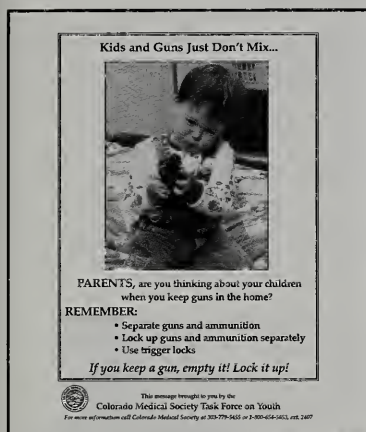
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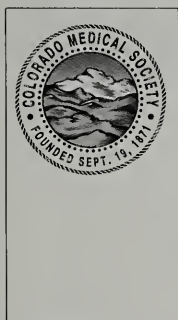
April, 1998

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Cover Story

It's a perfect time for us to ask that physicians remind their patients of firearm safety. Posters are going out simultaneously to all major news media with this magazine. Get yours today!



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CMS Board of Directors approves action plan for addressing Evaluation & Management (E & M) Coding Guideline concerns

At its January meeting, the CMS Health Affairs Council (HAC) was made aware of CMS member physicians' interests and concerns over the Health Care Financing Administration's (HCFA) Documentation Guidelines for Evaluation and Management (E & M) Services. In early February a letter was sent to all CMS members asking physicians for comments on these guidelines. HAC met again in February not only to review the immediate reaction to the call for comments, but also to consider what actions can be taken to encourage HCFA to re-think the intent, content and process of the implementation of these new requirements. This process will undoubtedly require long term grass-roots support by CMS and its members.

During its March 13 meeting, the CMS Board of Directors (BOD) approved the action plan proposed by the Health Affairs Council (HAC) to address member concerns over the revised E&M Coding Guidelines. The guidelines, issued by the Health Care Financing Administration (HCFA), have caused quite a stir around the state and nation among physicians who believe the documentation requirements of "evaluation and management" services are cumbersome, and may place physicians at risk for fraud and abuse if they do not accurately use the guidelines to record procedures. HAC has reviewed the guidelines and in February mailed a letter to all CMS members soliciting feedback. HAC also proposed that CMS:

1. Respond to the American Medical Association's (AMA) call for input from practicing physicians regarding problems with the documentation guidelines. This was done by a special mailing to all CMS members requesting that they get involved in the revision process. Subsequently, the responses from CMS members were compiled, summarized and sent to the AMA for consideration.
2. Send a letter to the AMA expressing overall concerns with the documentation guidelines. This letter has already been mailed.

3. Play an active role in bringing the problems associated with the documentation guidelines to the "public's" attention. A grassroots letter writing campaign has been initiated targeting HCFA officials, state and federal legislators and local and national representatives of the American Association of Retired Persons (AARP).

Physicians are encouraged to contact their state and federal legislators, the AMA and HCFA with their concerns. Following are some talking points which may be included in personalized letters:

- The guidelines are unnecessarily burdensome and divert attention from that of patient care to compliance with documentation requirements;
- the guidelines will have a negative impact on the quality of care;
- the guidelines are too complex and will have little impact on fraudulent billing practices;
- the additional work and risk of prosecution will have a negative impact on access to care for Medicare beneficiaries, as fewer physicians will agree to take on new Medicare patients.

Members are strongly encouraged to participate in this grassroots campaign. Please use the talking points above to customize personal letters. You may also download copies of the form letters developed by HAC from the CMS web page at www.cms.org, e-mail requests for the form letters to Marilyn_Rissmiller@cms.org, fax request to (303) 771-8657 or call Marilyn in the CMS offices at 779-5455, ext 2428, or 1-800-654-5653.

CMS is distributing these form letters to component societies around the state for dissemination to members. CMS is also contacting specialty societies and other state medical societies in an attempt to garner more support for this campaign.



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm
of Montgomery Little & McGrew, P.C.

*This column contains information concerning topics
of general interest in the medical-legal field. For further
information or help with specific problems, please
contact Montgomery Little & McGrew, P.C.*

Waiver of Insurance Deductible and Copayment:

Good Deed and Professional Courtesy, or Criminal Offense and Unprofessional Conduct?

A physician performs a sports physical exam for his jogging partner's high school son, or an ACL repair on a colleague's brother. As a professional courtesy, he writes off that part of the bill not covered by insurance; i.e., the patient's deductible and copayment. Is there any problem with this? There are laws limiting your ability to write off fees, and it can be a problem if you are not aware of the rules.

"Health insurance abuse" laws, aimed at the practice of waiving patient deductibles and copayments, are found in both the Colorado Medical Practice Act under the section describing "unprofessional conduct", and in our criminal statutes. Sections 12-36-117(1)(t) and 18-13-119.

In 1985 the general assembly passed the abuse of health insurance statute applicable to health care providers. The legislature found that business practices which eliminate the need for actual payment of required copayments and deductibles in health benefit plans, interfere with contractual obligations between the insured and the insurer relating to those payments. When conducted as a regular business practice, this type of "interference" is not in the public interest because it has the effect of increasing health care costs by removing the incentive that copayments and deductibles create in making the consumer a cost-conscious purchaser of health care. Furthermore, advertising a business practice of waiving

deductibles and copayments may aggravate the adverse financial and other impacts upon recipients of health care.

While the law allows waiver under limited circumstances (which may or may not include the above fact pattern), it forbids waiver as a regular business practice. And although the statute appears to target medical businesses that would attempt to attract patients with promises not to collect deductibles and copayments, the law has broad application.

If the effect is to eliminate the need for payment by the patient of any required deductible or copayment applicable in the patient's health benefit plan, a person who provides health care commits "abuse of health insurance" if he knowingly:

(1) accepts from any third-party payor, as payment in full for services rendered, the amount the third party payor covers; or

(2) submits a fee to a third-party payor which is higher than the fee he has agreed to accept from the insured patient with the understanding of waiving the required deductible or copayment.

The law provides not only that this type of business practice is illegal — a class 1 petty offense — but also that this business practice and the advertisement of this type of business practice would be grounds for disciplinary action under the Medical Practice Act.

There are however exceptions to the general rule prohibiting waiver of required payments by patients. First, reimbursements of deductibles and copayments are exempt if made pursuant to laws benefitting the medically indigent, the Medical Assistance Act, and federal medicare laws for inpatient hospitalization or community mental health services purchased.

Second, health care services provided to employees are exempt if the services are provided as part of the employee's salary or benefits under a contract or agreement between the employee and employer.

Third, the health care provider may waive the required deductible or copayment "for charitable purposes," if all the following conditions are met: (I) The person who provides the health care determines that the services are necessary for the immediate health and welfare of the patient; and (II) The waiver is made on a case-by-case basis and the person who provides the health care determines that payment of the deductible or copayment would create a substantial financial hardship for the patient; and (III) The waiver is not a regular business practice of the person who provides the health care.

(Continued on following page)

Professional courtesy waivers are not referred to among the list of exempt waivers, and if given often enough, may rise to the level of a business practice and health insurance abuse. Unless the professional courtesy waiver satisfies the requirements for a charitable purpose waiver, you could have a problem.

When does the determination to waive the copayment or deductible for certain patients become an illegal regular business practice? The statute tells us (in a very long sentence): "Any person who provides health care and who waives the deductible or copayment for more than one-fourth of his patients during any calendar year, excluding patients covered by [the reimbursement exemptions described above] or who advertises through newspapers, magazines, circulars, direct mail, directories, radio, television, or otherwise that he will accept from any third-party payor, as payment in full for services rendered, the amount the third-party payor covers shall be presumed to be engaged in waiving the deductible or copayment as a regular business practice."

Am I suggesting that it is not appropriate for physicians to waive fees as a professional courtesy? No. I am suggesting that a physician cannot run a medical practice using the business strategy of attracting patients through deductible and copayment waiver. And if "benevolent" waiver occurs more than 25% of the time, and without sufficient charitable justification, the physician could find him or herself on the slippery slope.

Don't forget: President Elect's Planning Conference, May 2-3, 1998, at the Sonnenalp, Vail, Colorado.

If you plan on attending and want to help CMS in its future direction, now is the time to register. You will find complete information on registration in this issue of **Colorado Medicine**.

For assurance in obtaining hotel space at the Sonnenalp, reservations must be received on or before April 17th. Reservations received after this date will be taken on a space-available basis only.

The Cancer Clinical Trials Task Force of Colorado

by Peter Reich

Colorado physicians and patients have access to new cancer treatment approaches, investigational agents and cancer prevention, and control strategies, by participating in National Cancer Institute (NCI) approved clinical trials through the University of Colorado Cancer Center and the Colorado Cancer Research Program. However, nationwide it is estimated that only three to five percent of adult cancer patients participate in clinical trials. Many factors inhibit greater participation, including that the cost of care for patients on such clinical trials often are not covered by the patients' health plans. A recent survey of medical oncologists throughout the US indicated that 37 percent of respondents reported insurer denial of approval for participation in a clinical trial for at least one of the physician's patients, and 38 percent indicated that they would place at least one additional patient on a clinical trial if the insurer were to cover the cost.

The Cancer Clinical Trials Task Force of Colorado was formed two years ago in order to find a non-legislative solution to the uncertainty of coverage by third party payers for cancer patients on clinical trials. The Task Force evolved from an initial meeting held in December 1994 with BlueCross/BlueShield officials and representatives of the Colorado Medical Society and the American Cancer Society. Shortly thereafter, a meeting with officials from the then FHP was also encouraging, and regular meetings have been held since, including, in addition to the above, representatives from the major Colorado health plans, as well as from the Rocky Mountain Oncology Society, the University of Colorado Cancer Center and the Colorado Cancer Research Program (CCRP), a consortium of nine front range community hospitals.

During the past two years the Task Force has provided information and education about the role of clinical trials in providing effective cancer treatment and answering clearly defined questions to guide future therapies. Specific NCI and FDA approved cancer treatment clinical trials are reviewed by a panel of community and academic cancer specialists. Three levels of information about these trials are provided or made available to the medical directors of the HMOs. The first is a concise "Fact

(Continued on page 4)

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Colorado Alliance for the Mentally Ill 1998 Annual Conference "Keeping the Focus on Good Care".

April 24-25
Raintree Plaza Conference Center,
1900 Ken Pratt Blvd., Longmont, CO.
For information & registration, call (303) 321-3104.

Fifth Annual Colorado Safety and Injury Prevention Conference

April 29, 30 and May 1
Beaver Run Resort
Breckenridge, CO
(303) 861-6628

**Colorado Medical Society
President-Elect's Planning Conference**

May 2 - 3, 1998
Sonnenalp Resort, Vail
Mail Registration to CMS, PO Box 17550,
Denver, CO 80217 or fax to (303) 771-8657.

**Colorado Otolaryngology and Maxillofacial Society
Rocky Mountain Ear Round-up**

July 23 - 24, 1998
Brown Palace Hotel
321 Seventeenth Street
Denver, CO 80202
Contact: Bob Conlon, MD or Debbie Brown,
(970) 484-8686

Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send details to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include details of program sponsor, date, location and who to call for more information.

Shoot", which summarizes the major treatment components in the trial, identifies potential benefits versus side effects and toxicities, if any additional costs are engendered, if any agents are provided free of cost, and a brief scientific evaluation. The second is the "Fast Facts", which is a two to four page summary of the salient portions of the clinical trial protocol. The third is the complete study protocol, which is available on request. This review process concentrates on those studies that are expected to have a sizeable accrual in Colorado, or where challenges have occurred or might be expected.

The establishment of this non-confrontational approach to increase coverage of patient care costs for patients on poor-reviewed Phase III cancer clinical trials was unique in 1995. Since then other efforts have been reported which extend coverage to certain populations on specific clinical trials. Also in 1996, the national BlueCross/BlueShield Plans agreed to provide its clients with access to pediatric cancer clinical trials through the two national childhood cancer cooperative study groups. In September of 1997, three adult cooperative groups sponsored by the NCI reached agreements with several health insurance plans in Wisconsin and Minnesota to cover care costs of patients on clinical trials through these cooperative groups.

The response to the Colorado program has been an enthusiastic endorsement by the health plan organizations and the providers, including financial support to the Task Force coordinating office located at the offices of the Colorado Cancer Research Program. The implementation of this program has been associated by fewer denials for clinical trials coverage, a heightened awareness of the crucial role of clinical trials in defining new treatment strategies, and an appreciation of the need to invest in present clinical trials in order to be able to set accepted standards for future therapies. We are in the process of assessing the program's impact with a participant questionnaire and with tracking of denials, impact of follow-up information, and ultimate outcome.

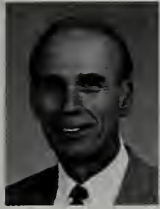
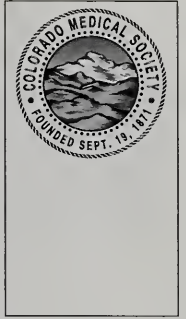
The author encourages any physician interested in the activities of the Task Force or wishing to relate difficulties with patient coverage for clinical trials to contact:

The Cancer Clinical Trials Task Force of Colorado
c/o Ms. Susan Reddy
Colorado Cancer Research Program (CCRP)
3955 East Exposition, Suite 104, Denver, CO 80209
Fax: 303-777-2642 Tel: 303-777-2663.
e-mail: ccrphp@aol.com

References:

1. Mortenson LE et al. The Impact of Managed Care on Oncology practice. *Oncology Issues* Sept/Oct. 22 - 27, 1997
2. Raich PC et al. Can HMOs be educated regarding cancer clinical trials?

J. Cancer Education Supplement to 12(3):96, 1997.



Gary D. VanderArk, MD
President, 1997-1998

Let's Remain a Profession

Yes, the profession of medicine is on a slippery slope. We are being buffeted on all sides to shed our historical commitments to professionalism. However, we can survive as a profession. The Colorado Medical Society is totally committed to make it happen.

CMS is making the three A's of VanderArk's agenda a reality. Advocacy, Access and Accountability are what the CMS is all about.

CMS is involved in physician advocacy and patient advocacy. I was shocked when last year's president, Ray Painter, estimated that 80% of CMS's advocacy was for patients. However, when you look at how we spend our time and resources, you may come to the same conclusion. The Managed Care Task Force was established to advocate for physicians with insurers, but in the past two years we have put a huge effort into the disclosure project for the benefit of our patients. This year has been one of our busiest years at the State House. We have had to follow more than 60 bills. The proposed legislation to which we have devoted most of our resources is once again about patient advocacy. The CMS will do something about the terrible E&M codes that HCFA wants to implement. Your Health Affairs Council is looking out for your interests, but modifying the E&M codes will also benefit our patients.

CMS is responsible for both CROP and the Coalition on Colorado's Medically Underserved. Both of these programs are about access. The Coalition is already actively working on expanding

existing programs, such as The Children's Basic Health Plan, and increasing enrollment in Medicaid. There will be more volunteer efforts to care for the underserved. A comprehensive incremented plan will be proposed to dramatically transform the medically underserved population. *We are committed to remove any substantial differences in access to quality healthcare and the prevention of illness among all the people of Colorado by 2007.*

CMS is leading the way to accountability. You can no longer pick up an issue of Colorado Medicine without seeing an article on outcomes. We are committed to a method of problem solving that recognizes that nobody knows it all, and acknowledges that not everything we do has been validated. Your Accountability Committee has developed and implemented a joint data project with eight HMO's on the management of diabetes mellitus. This will be the first of many such projects that will provide a model for state medical societies across the nation.

The Accountability Committee is also working on a new patient satisfaction survey and, in collaboration with COPIC and Gadrian, on the physician profile project.


Yes, medicine can remain a profession, but if that happens it will require your support of the CMS. I hope you are all as proud of the CMS's activities as I am.

"We are committed to remove any substantial differences in access to quality healthcare and the prevention of illness among all the people of Colorado by 2007."

(Continued on following page)

Out of prescription pads?

Who can you trust to print these important documents? Trust the Colorado Medical Society.



John Smith, M.D.
1234 Unknown Dr.
Denver, CO 80210
(303) 555-5555
DEA # _____

*Member of the
Colorado Medical Society*

Name: _____ Age: _____
Address: _____ Date: _____

Rx _____

☐ Label
☐ No Generic
☐ Generic OK

Signature: _____
John Smith, M.D.

Refill 0 1 2 3 4 5 6 Times

Physicians advocating for their patients for over 126 years

**NCR sets
now
available!**

To order your Rx pads please fill out the form below with your information and return it to: Colorado Medical Society, P.O. Box 17550, Denver, CO 80217-0550, ATTN: Communications Dept. Please make checks payable to Colorado Medical Society. Other questions please call (303) 779-5455 or 1-800-654-5653 ext. 2425 or 2418.

Name: _____
(please specify M.D. or D.O.)

Address: _____
(35 character maximum, including spaces)

City: _____ Zip Code: _____ Phone: _____

Plain paper and alter-proof NCR Rx pads are available. Plain pads consist of 100 pages of 20 lb. stock paper, printed with the personalized information you supplied above, and padded. NCR sets allow you to retain a copy of every Rx you write. Shipping and handling is included in the cost. **To order check below:**

PLAIN PAPER PADS

- ☐ 10 pads for \$9.25 ☐ 20 pads for \$16.25 ☐ 30 pads for \$22.95 ☐ Other (please call for prices)

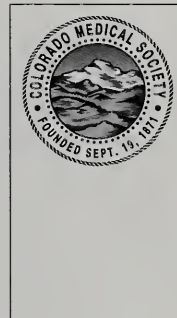
NCR SETS

(These are not padded. Sets include white original plus a pink second-sheet)

- ☐ 1000 sets for \$31.20 ☐ 2000 sets for \$62.40 ☐ 3000 sets for \$93.60 ☐ Other (please call for prices)

Orders must be received by April 30, 1998 to be printed in second quarter

Order today and let your patients know that you are a proud member of the Colorado Medical Society



Sandra L. Maloney
Executive Director

Speaking of Horns. . .

. . . well, I admit that no one was, but I am going to assume the Executive prerogative and speak of them. In fact, I'm going to blow our collective CMS horn.

What has moved me to do this has been the just-completed Interim Meeting of the House of Delegates and the manner in which it was performed and conducted.

When I say performance, I am

- speaking of all of the minute details which make the meeting go smoothly
- talking about the myriad details of each assigned tasks among the CMS physician members, i.e., Speaker, Vice-speaker, Parliamentarian, Sargents at Arms, Committee chairs and members, committee testifiers
- CMS staff that prepared the way for these tasks to be performed rather effortlessly, such as
 - a. meeting planning and liaison with hotel management and staff
 - b. pre-registration of delegates and preparation of registration materials, in conformance with the CMS By-laws for record-keeping, reporting, voting and attendance
 - c. coordination with hotelbanquet staff for meals, snacks, coffee and refreshments
 - d. the thousand-and-one details about which nobody thought or knew would crop up after the meeting was under way.

And then, as many of our more than 5,000 members who were not in attendance could not know, what used to be a two-day, all-business Interim Meeting has now grown into

a three-day meeting including the all day Friday "Annual Medically Underserved Conference." This was a literally seamless occurrence with our Finance Committee, Board of Directors and guests being able to conduct their business and still take part in the conference, which was ... just great! There were over 200 health-care providers and interested parties in attendance. The awards banquet was a very fitting climax to the full day conference. The keynote speaker, Dr. Reed Tuxson of the AMA, was indeed a fitting highlight to the entire 13-hour event. Wish you could have been there.

If you haven't noticed before now, this was CMS' **second** annual conference on the underserved of Colorado, and I am almost certain that we'll see this conference as a regular event, and that's super-good news for CMS.

In February, I attended the annual Executive Director's meeting of the American Association of Medical Executives (AAMSE). Directors from all 50 state medical societies were in attendance. We share ideas, problems, solutions and a variety of information about conducting these organizations. Believe me, when you get through with one of these meetings, you can certainly understand where Dr. John Sbarbaro got his description of physician organization leadership: *"Trying to direct physicians is like trying to herd cats."*

As always, I went to this meeting wondering just where CMS during the past year might have missed out on sprovinding ome important member service.

***"All of you out there ...
Listen Up!
Don't make me yell!
It's braggin' time around
the campfire"***

After that meeting, and following our Interim Meeting, I realized just what an effective organization CMS actually is, comparing it with even bigger medical societies. You may not see the results, but believe me there are a lot of services which CMS (members and staff alike) takes for granted. When we sit down and start comparing notes with other like organizations, I find a source of great pride in what we do accomplish.

Read this issue of **Colorado Medicine** cover to cover and I think you'll get a pretty good idea of why I'm blowing our horn. I think I (or somebody) ought to do **more and louder tooting!**



THE LOBBY

by Christopher Unrein, DO, Chairman
Council on Legislation



"I am sure there are other social controversies that I have not highlighted. . ."

The Colorado Medical Society is a democratic organization. The policy-making body of this organization is the House of Delegates. Frequently the Board of Directors makes decisions that are later ratified by the House of Delegates, since it only meets twice a year. All regions of Colorado are represented on the CMS Board of Directors and in the House of Delegates. The Council on Legislation also has geographic representation. This council is charged with enforcing CMS policy and to use its judgment when no specific policy is available. Decisions made by the Council are ratified by the Board of Directors and are ultimately reported to the House of Delegates.

Leaders within the CMS do *not* arbitrarily make policy to suit their own needs. In fact, a CMS leader might end up enforcing policy that is in direct opposition to his own belief. Having said all that, I wish to remind you that the slogan on the cover of *Colorado Medicine: Advocating excellence in the profession of medicine*. This is our true mission at CMS.

I wrote an article last month about how certain legislative issues have the potential to drive us apart and that we must be wary of that fact. I must reiterate this theme because of recent legislative controversies and the subsequent vehement feedback I have received. The Legislative Council has grappled with several hot issues since my last article. In discussions about these issues, testimony for and against each is almost always presented by CMS staff, outside sources, and by Council members themselves. This means that some viewpoints will be in the minority and will not be our main focus because of established CMS policy.

As I said last month, a divided house cannot stand. Medicine faces many challenges from within (primary care vs. procedural care) and challenges from outside forces (health care finance reform and non-physicians extending their scope of practice into ours). For the sake of maintaining our professionalism, our agenda must focus on the interests of physicians, patients, and the unique relationship that exists between them. In order to preserve excellence in the profession, we oppose, **at all costs**, efforts to make acts of medical practice criminal, and/or to codify interference with the physician-patient relationship.

Council members realize that there are varying positions on moral and ethical issues within the membership of CMS. This is a reflection of society as a whole. Therefore, it has been our position not to choose sides on such issues as gun control and abortion because these are

divisive and will only catalyze unrest that usually lies dormant within CMS. It has also been difficult to address euthanasia because physicians disagree about this as a "service" that physicians might provide, yet we know there is more to learn about end-of-life care.

I am sure there are other social controversies that I have not highlighted here. I recently heard, and agree that "It is not always appropriate to legislate that which is offensive." We have different views and need to respect one another. I would like to continue the tradition of intelligent discussion and professionalism that lured me to volunteer in this position. At the risk of being redundant, and for the sake of preserving our professional goals in organized medicine, let's agree to disagree about complex social issues that are beyond the scope of the Legislative Council.

This year, the Council on Legislation has taken positions on 64 legislative bills all of which are described in the CMS Legislative Digest. A copy of the digest may be obtained by calling your Department of Government Relations at 1-800-654-5653 or 779-5455, Ext. 2413. Internet subscribers may check the CMS Web page for updated legislative information by visiting the CMS Home Page (<http://www.cms.org>). Select "CMS for Physicians", then select "Heard on the Hill" for a current list of CMS legislative activity. A few of the bills of high priority are listed here for your information.

(Continued next page)

THE LOBBY (Continued)

SB 36, Requirement for Licensure of Physicians Lawfully Practicing Medicine in Another Jurisdiction (Wham): CMS supports this bill which adds language to the Colorado Medical Practice Act requiring persons from out-of-state to hold a Colorado license if they practice telemedicine on more than an occasional basis. The bill has passed both houses and we are awaiting appointment of a conference committee to consider amendments made in the House which exempt CLIA labs from the licensing requirements.

SB 57, Reinforcement of the Criminal Prohibition Against Assisting Suicide (Tebedo): The CMS opposed this bill which added language to the current Colorado manslaughter statutes. The bill was killed in Senate Judiciary Committee.

SB 75, Governmental Immunity for Certain Health Care Professionals Employed by Public Entities (Thiebaut): CMS opposed this bill which would have eliminated governmental immunity for physicians and dentists employed by public entities. The bill was killed in the Health, Environment, Welfare & Institutions (HEWI) Committee.

SB 99, Needle Exchange Program: Would have enabled the establishment of needle exchange programs and exempted a locally established needle exchange program from prosecution under Colorado drug paraphernalia laws. CMS supported the bill which passed the Senate but was killed in the House HEWI Committee.

HB 1046, Limited Prescriptive Authority for Chiropractors (Musgrave): This bill which was killed in Committee would have authorized chiropractors who obtain limited prescriptive authority to prescribe and administer specified

pharmaceutical agents. CMS opposed this bill as well as an attempt on the House floor to place similar language on another bill.

HB 1104, Reduction on Mandatory Automobile Insurance Coverage Amounts (Veiga): Those of you who responded to CMS "Alerts" played a major role in getting this bill killed. Had it passed, current mandatory minimum automobile insurance coverages would have been reduced from \$50,000 to \$5,000 in medical benefits.

HB 1216, Collaborative Drug Therapy Agreements Between Physicians & Pharmacists (Paschall): CMS opposed this measure which allowed physicians and pharmacists to enter into collaborative drug therapy agreements for the purpose of drug therapy management. The bill was killed in Committee.

You're too busy practicing medicine to play politics

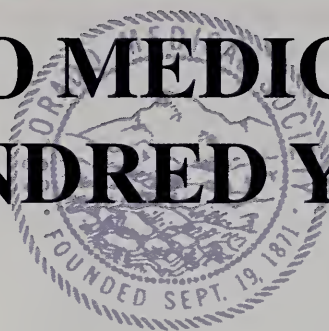
Every day you see the effects of health care reform on your practice. Every day you promise yourself that you will become more involved and help shape the future of medicine. But the truth is that sometimes you are just too busy.

Fortunately you have COMPAC. Legislators are becoming aware of and educated by organized medicine. However, the Campaign Reform Amendment and legislator turnover in both Houses in 1998 may dramatically affect the legislative advances made for you and your patients.

Join COMPAC today and become personally involved in the future of health care in Colorado. Then rest assured the voice of organized medicine will continue to be heard at the state legislature. For information call (303) 779-5455, ext. 2410 or 1-800-654-5653.



COLORADO MEDICAL SOCIETY ONE HUNDRED YEARS AGO



***IN 1898**

Colorado Medical Society, then 27 years old, had 511 members.

***IN 1998**

Colorado Medical Society, now 127 years old, has 5,260 members.

In 1898, Colorado had been a state only 22 years, and the economy and population base was chiefly agricultural and mineral, which meant that the majority of people were working with their hands in decidedly rural parts of the state.

In 1998, one hundred years later, a large percentage of Colorado's population still lives in rural areas, few of whom depend on agriculture or mining economies, but who still have one major factor in common.

Neither then nor now do 100% of Colorado's residents have necessary and proper medical treatment at hand; both then and now, they suffer a shortage of medical practitioners domiciled in these rural areas of the state.

What IS different about 1998 is that Colorado Medical Society has created
C.R.O.P. (Colorado Rural Outreach Program)

to fulfill the medical needs of the state's many rural areas, but your help is needed. CROP Foundation is anxious to have your help in this program to place physicians in the rural areas of Colorado.

***IN 1998**

there is no good reason why CMS can't help supply the physicians necessary to the rural populations through CROP (Colorado Rural Outreach Program) Foundation, if you will participate by contributing your time and knowledge.

Please...call or write for details on how you can help.

Contact the Foundation office at (303) 930-0407 or 1-800-654-5653, extension 2407

Bullseye!



by Chet Seward, Director
CMS Health Care Policy Division

Medically Underserved Coalition Right On Target 2nd Year

The second annual *Caring for Colorado's Medically Underserved Conference* was held on March 13. The theme of last year's conference was "a beautiful beginning". This year one might say that the beautiful beginning has grown to become a bright light on a dark problem. The conference was a success, providing the opportunity for over 200 care providers and others to meet, network and become re-energized about the critical work they do. Everyone made a contribution. Last year Colorado "took a stand" for the underserved. This year that commitment and resolve continues to grow and shine even brighter.

The genesis of last year's meeting has grown to become the Coalition for the Medically Underserved. Funded by a grant from The Colorado Trust, the Coalition has taken the major points from last year's conference and is now using them to devise a statewide action plan for Colorado. Dr. VanderArk updated attendees at this year's conference about how this diverse group of physicians, legislators, state policy makers, hospital and community health administrators, insurers and business leaders is meeting on a monthly basis to devise an incremental strategy which will remove any substantial differences in access to quality health care and prevention of illness among all the people of Colorado by the year 2007. It is an auspicious goal, but conference attendees agreed that Colorado's health care community is ready and willing to make it a reality.

Other highlights of the conference included the keynote address

by Jack Lewin, MD. Dr. Lewin, Executive Vice President of the California Medical Association, presented statistical and anecdotal examples of how the market forces in California continue their ruthless competition and have begun to divest themselves, thereby passing on more costs to patients. He noted that the employer purchased health care system will continue to lurch along, indirectly avoiding the access and quality issues of the underserved which will only increase the burden on the safety net. He contends that the health care community and society in general are suffering from "mural dyslexia", a state in which we cannot or will not read the handwriting on the wall. Dr. Lewin contended that innovative solutions and leadership must come from the health care community in order to stand up for those that the profession has sworn to serve.

Barb Yondorf, Director of Policy and Research, Colorado Division of Insurance, corroborated many of Dr. Lewin's concerns when she updated the group on the forthcoming edition of the Colorado Health Sourcebook. Using a wide range of current statistics, Ms. Yondorf showed that the number of uninsured in Colorado continues to grow, employer sponsored health insurance has decreased and costs are being shifted to employees. Federal and state programs like Medicaid and the Child Basic Health Plan will experience continued stress to provide more services to a growing population of the underserved while

Patients and providers speak out on low- and no-care health issues and answers.



Ellen Stein shown receiving the layperson award for her work over many years on behalf of the underserved as Director of the Health Care Policy Department at CMS. Ellen, shown with CMS President and Coalition Chairman Dr. VanderArk, is now the Executive Director of Safehouse Denver.

(Continued on following page)

Bullseye!

(Continued from preceding page)

funding sources are constricted.

These somewhat grim but motivating statistics were followed by a panel of patients who have accessed the current system. The emotional testimony by Jackie Trainer, Kim Montgomery and Dora Kyser was a highlight of the morning, spotlighting the problems they face in obtaining health care and dispelling some of the myths surrounding the underserved. One key point that was raised by all the panelists was the need for better information about programs that currently exist. If it were not for local, community health centers they all agreed that their only other resource for care would be the emergency room at Denver Health.

Kevin Barnett, Dr.P.H., principal investigator at the Public Health Institute in California, explored the complicated nature of evaluating the community benefit that hospitals and other organizations provide to the public. Given recent reports of hospital profits and continued access challenges for the uninsured, Dr. Barnett's presentation shed some light on the how charity and uncompensated care can be evaluated and promoted. Sen. Sally Hopper followed with an update on current legislative reform affecting access and quality of care for the underserved. Bernie Beuscher, former director of the Colorado Department of Health Care Policy and Financing, detailed the current status of the implementation of the Child Basic Health Plan and other state programs. Patricia Gabow, MD, CEO/Medical Director of Denver Health Medical Center, succinctly explained the intricacies of the Disproportionate Share Hospital (DSH) program which combines hospital, state and federal funds for safety net hospitals around the state. All three panelists overviewed strategies to increase access to care like expanding Medicaid coverage for low income children, advocating for increased general funding of the

Child Basic Health Plan to pull down a two for one dollar match from the federal government, and refining the way DSH funds are collected and then redistributed to more efficiently finance the program.

This year a poster session was added to the lineup of conference events. Organizations that care for the underserved presented posters about their programs in three categories: serving special populations, collaborative efforts and model programs for caring for the underserved. The poster session was

benefit and systems change. Each group had lively discussions and developed thoughtful recommendations. Noteworthy conclusions include: the need to widely disseminate information about existing programs; innovative financing systems must be explored to preserve the safety net; fractured information systems can be addressed by standardizing forms and eligibility requirements across state run programs; quality of life and quality of health go hand in hand. While no one seeks a medicalization



Featured participants in the 2nd Annual CMS Conference on the Medically Underserved shown at the Friday evening Awards Banquet are (l-r) Dr. Gary VanderArk, Reed Tuxson, MD, Group Vice President for Professional Standards at the American Medical Association, Ellen Stein, Safehouse Denver, Donald E. Cook, MD, honored as Physician of the Year for his work at the Monfort Children's Clinic in Greeley, Kristine Wooley who received the Award for Non-physician Provider for her work as clinic director at Doctors Care in Arapahoe County, and; speaker Jack Lewin, MD, Executive Vice President of the California Medical Association.

well received with over 30 participants from all over the state. A panel of judges from the Coalition had the difficult task of choosing winners. In the end Farmworker Health Services of Colorado won the serving special populations category, Loveland Community Health Center took first prize in the collaborative efforts classification and CUCare Health Plan took top honors in the model programs for caring for the underserved group.

Breakout sessions in the afternoon featured expert speakers in policy, data sharing, community

of social ills, there are many other factors and players which must be considered; systems to measure outcomes must be implemented to improve preventive and quality care; the public must become more aware of the problem in order for it to be adequately addressed; and universal coverage must continue to be the end goal.

Dr. Larry Kieft, from the Poudre Valley Prenatal Program, eloquently summarized the major message of all the breakouts by stating that even

(Continued next page)

Bullseye!

(Continued from preceding page)

though the problems of the underserved persist, the resolve of those providing care is steadfast and strong. Patchwork solutions, unknown capacities for current programs, inefficiencies in financing, tension between the big picture and the grassroots perspective, and the fact that solutions are often driven by opportunity instead of need are all factors that must be addressed. The Coalition can play a role. Answers will not be found in quick solutions. Instead Dr. Kieft encouraged attendees to persevere with their work referencing a phrase from a biblical song: "Dare to be a Daniel, Dare to stand alone, Dare to have a purpose firm, Dare to make it known".

The resolve and tenacity of the afternoon changed to passion during the Awards Banquet as community service awards were presented and Reed Tuckson, MD, addressed the banquet. Awards were given in three categories for those who have made outstanding contributions for the underserved. Donald E. Cook, MD, was honored as physician of the year for his work at Monfort Children's Clinic, Kristine Wooley won the award for non-physician provider for her work as clinic director at Doctors Care in Arapahoe County, and Ellen Stein took home the layperson award for her work over many years on behalf of the underserved as Director of the Health Care Policy Department at CMS. Dr. Tuckson, Group Vice President for Professional Standards at the American Medical Association, gave a moving speech.

He has spent most of his life caring for and teaching others to serve the underserved. His message wove together many of the effects, emotions and encouragement of the day. The handwriting is on the wall and the "screams in the night" continue to make this problem obviously apparent. As professionals, the health care community cannot and should not stand for anything less than resolving the problems of the underserved. There is a long and dark struggle. It is through conferences like *Caring for Colorado's Medically Underserved*, actions by groups like the Coalition for the Medically Underserved, and work by dedicated individuals that light can be shed on their plight. In the end, Dr. Tuckson concluded, "the darkness can be lifted...We should strive for nothing less".

'98 Interim Meeting "Quick Takes"



There were many highlights to this Interim meeting, but we could only get to a few. Here (clockwise, from lower left) Boulder County Medical Society President Mary E. Faini presents Jack Cletcher of Longmont with a special award for his service to Boulder County physicians with his participation on many committees and councils. He was also recognized, with Dr. Jack Berry of Wray, for their services to the Colorado Rural Outreach Program (CROP); and finally, three members of the CMS Alliance were lauded for the part they are playing in the organization. From the left, Leslie (Dr. Robert) Nathan and Sue (Dr. Robert J.) Foerster of Colorado Springs will be co-presidents of the Alliance for the 1998-99 year. Stella Shanks of Grand Junction, the Alliance's outgoing President, introduced the new officers during her annual report to the House.



GUEST EDITORIAL

by Matthew Hine, M.D., M.P.H.

Fellow, American College of Preventive Medicine
Colorado Springs, CO

"Marijuana ... has been recommended by doctors ... is not physically addicting, and not one case of human death due to its use has been credibly documented."

To the Editor :

I wonder if politicians are reluctant to appear soft on "drugs" for fear of losing votes (a rational course of behavior), or if they are afflicted with a bizarre thought disorder regarding "drug" policy.

Researchers at the World Health Organization have recently reported that cannabis (marijuana) is in many ways safer than tobacco or alcohol (New Scientist Magazine, February 2, 1998).

Against this backdrop, Vice President Al Gore recently addressed a packed gymnasium at Boston's McCormack Middle School about the dangers of tobacco. After he asked his young audience for ways to snuff out smoking, Gore rejected

the first idea he was offered. "Why don't you close all the tobacco factories and farms?" asked 11-year-old Jose Negroni. After a pause, Gore answered "You can't do that." He said it would be akin to Prohibition, the government's failed effort to enforce a ban on alcohol in the 1920s. "There are so many adults who are addicted, that if you try to outlaw the whole industry you'd have a horrible law enforcement problem", he said. (Massachusetts Standard-Times, March 15, 1998.)

Really!

Would someone please remind Mr. Gore that he has admitted being one of over 70 million Americans who have broken the law by smoking marijuana? Over ten million Americans have been arrested on marijuana charges since the National Commission on Marijuana and Drug Abuse issued its recommendation to Congress in 1972 that marijuana be decriminalized - 640,000 arrests in 1997 alone. As a result, our prisons are bursting at the seams.

Due in large part to the U.S. War on marijuana users, our country now has the distinction of incarcerating a larger percentage of our population than any other nation on earth, including Russia and China. Mandatory minimum sentencing results in longer sentences for non-violent offenders than for murderers or rapists. The housing and feeding of each prisoner bleeds off over \$20,000 per year of taxpayer's money.

There is no argument about the need to keep children away from alcohol, tobacco and marijuana, but

the strategies are quite different. The politicians seem to believe that kids will be spared marijuana's harms by exaggerating its risks and enforcing strict penalties for any use. But when it comes to tobacco, we should trust the tobacco industry to help keep kids away from their product.

To show how ludicrous this is, imagine reversing the situation. Picture a world where marijuana manufacturers are allowed the power to negotiate regulation, even as they receive subsidies from the federal government, and where pot is available at every gas station and grocery store. Imagine citizens who risk forfeiting their liberty and property for possessing the smallest amount of tobacco, while they are scolded by editorialists for not thinking negatively enough about the "demon drug".

Tobacco addicts millions and causes hundred of thousands of premature deaths each year, including second-hand smokers who didn't even make the choice to use it. No one suggests tobacco has medical value.

Marijuana, on the other hand, has been recommended by doctors to patients suffering from AIDS, the side effects of chemotherapy, and a variety of plastic muscle disorders, among other maladies. It is not physically addicting, and not one case of human death due to its use has been credibly documented.

The myths that the use of marijuana causes a person to become an abuser of "hard drugs", or that marijuana causes brain

damage have been disproven long ago. (Marijuana Myths, Marijuana Facts: A review of the scientific literature, by Lynn Zimmer and John Morgan, published by The Lindesmith Center, 1997.)

Cannabis has been used as a medicine in China, India, the Middle East, southern Africa and South America for centuries. In the 19th century, it was respectable enough to be used by Queen Victoria's doctor to alleviate her labor pains. It was commonly prescribed by medical doctors in the U.S. until the early 20th century.

Today, licensed physicians who routinely prescribe far more dangerous "drugs" are legally forbidden to provide people who are dying, going blind, or being crippled with therapeutic access to marijuana. This

stark conflict between medical needs and federal policies has created a situation in which desperately ill patients turn to the streets - and criminality - to meet their legitimate medical needs.

In 1988, after reviewing all evidence brought forth in a lawsuit against the government's prohibition of medical marijuana, the Drug Enforcement Administration's own administrative law judge (Francis Young) wrote: "The evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasonable, arbitrary and capricious for the Drug Enforcement Administration to continue to stand between those sufferers and the benefits of this substance in light of the evidence." The DEA chose to disregard the

judge's opinion.

Since that time, many prominently respected individuals and organizations have recommended a regulatory rather than a prohibitionist approach to marijuana.

My preferred recreational "drug" is one you wouldn't want your kids to get hold of. You see, I've graduated to the hard stuff. Used inappropriately, it's addictive, causes liver and brain damage, and is linked to increased violence. The social and health costs associated with its use are horrendous. Even if it can be proved that most people use the "drug" in moderation, the chances of any modern government legalizing it are small. This is fortunate. Alcohol, after all, has been around so long, and is so ubiquitous, that the only way to control it is to regulate it.

Yours Truly,
Matthew Hine, M.D., M.P.H.

Call for Nominations

Colorado Medical Society Certificate of Service

Each year, Colorado Medical Society awards a physician with the prestigious Colorado Medical Society Certificate of Service, recognizing outstanding effort and devotion to the purposes of organized medicine. The award is given to an individual who displayed unusual efforts on behalf of the Colorado Medical Society, or noteworthy contributions to the practice of medicine in Colorado.

This award, given by the Colorado Medical Society House of Delegates at each year's Annual Meeting, goes to a physician named by his/her peers. You are urged to consider this award and the activities at both state and local levels, and nominate that individual whom you feel has made an outstanding contribution.

Nominations are due on or before June 30, 1998.

Please call CMS at 1-800-654-5653 or (303) 779-5455, extension 2418, to request a nomination form.



by Gary D. VanderArk, MD
Rocky Mountain Neurosurgical
Alliance

Outcomes for Dummies

"We ask questions about things we are willing to change."

I have the firm conviction, as everyone who reads **Colorado Medicine** already knows, that everyone in medicine can and must be involved in demonstrating outcomes for their patient care. Many of the experts in our state have already published their ideas about different methods of doing outcomes, but now I want to make it really simple and really practical and challenge everyone to really do it.

In our office of five to seven neurosurgeons, we have created our own homemade, simple form for surveying our patients. We ask questions about things that we are willing to change. Our questions are all on one side of one piece of paper that is computer scannable. Our surveys have resulted in dramatic change in our office, but no additional personnel or equipment. Our patients and our employees found all commercially available alternative questionnaires objectionable.

Now, I admit that we have a procedurally-based practice. We do have an event (surgery) that produces an outcome. We have chosen to measure our outcomes with simple measuring sticks, i.e., do you still have pain? Are you back at work? Have you returned to the same work?

We vary the procedures that we are trying to evaluate from time to time, but always survey 90 days post procedure. Our surveys are sent with a cover letter which says "Please" and a stamped, addressed envelope. We have consistently received a 40% return rate and have made no additional attempt at follow-up.

As an example of our data, Figure 1 shows the results of 602 back and neck procedures done by our group in 1996. Eighty-seven percent of these patients were back at work three months after surgery, and eighty percent were back doing the same job that they had done before developing back or neck problems.

The greatest criticism that our method has received is that we

cannot compare our results with anyone else. Because that bothered us, too, we went to Swedish Medical Center medical records and dug out the data on DRG 214, which includes all non-complicated back and neck patients who had surgery. As Figure 2 illustrates, we think we stack up pretty well with the rest of the world too.

I think the real reason for doing outcomes, though, is because it changes behavior. If you do outcomes in your office, it will change things.

Our office changed many policies because our patients told us what they wanted. We used to turn over our phones to the answering service at noon, so everyone could have lunch together. Our patients said that for them, the noon hour was a convenient time to call, and they were frustrated to get the answering service. Now, we stagger lunch breaks and someone in the office always answers the phone. We have reassigned and even replaced employees on the basis of our

Back and Neck Surgery

Outcomes-602 patients in 1996

How helpful was surgery	84% Excellent - Very Good
Pain Relief	67% Excellent - Very Good
Back at work in 3 months	87%
Back at regular job	80%

Figure 1

(Continued on following page)

ACCOUNTABILITY (Continued)

patient surveys.

We had a very slick, expensive brochure that outlined our practice policies, but patients said it did not tell them what they needed to know, so we replaced it with a new, much cheaper version that gives the information they said they needed.

We have dramatically decreased the number of unauthorized

managed care encounters by developing a new computerized referral program.

One of the most amazing things that we have proven with our outcome program is that physicians can change just like everyone else (even if they are neurosurgeons). Doing outcomes results in a uniform, best-practice way of doing things.

So stop what you are doing right now. Sit down with your

secretary, office manager or practice administrator and talk about what you need to know. Then, ask your patients. They will be happy to tell you, and your practice will never be the same.

Back and Neck Surgery

Outcomes-602 patients in 1996

How do we compare with the world?

DRG 214

	Severity	LOS	Mortality	Charge
Group	0.2	2.1	0	6844
Total at Hospital	0.2	2.6	0	9297
National database	0.2	4.1	0	11042

Figure 2

Patient Survey: Why do we do it?

- Employees change -- or else
- Policies change
 - *New patient brochures
 - *Extended phone coverage
 - *Enhanced computerized managed care referral program.
- Doctors change.

Why this form?

- Computer scanned
- Patients will fill it out
- Easy access to reports and results.

Scott Weingarten on

"Why do outcomes?"

Every morning in Africa, a gazelle wakes up. It knows it must run faster than the fastest lion or it will be killed.

Every morning in Africa, a lion wakes up. It knows it must outrun the slowest gazelle or it will starve to death.

It doesn't matter if you're a lion or a gazelle; when the sun comes up, you had better be running.

VanderArk's Rules for Outcomes

- Rule 1 - Indecision is the key to flexibility.
- Rule 2 - I have seen the truth and it makes no sense.
- Rule 3 - If you can smile when things go wrong, you have someone in mind to blame.
- Rule 4 - Never argue with an idiot. They drag you down to their level and then beat you with experience.
- Rule 5 - Someone who thinks logically is a nice contrast to a group of surgeons.
- Rule 6 - Everything should be made as simple as possible...but no simpler.
- Rule 7 -The facts, although interesting, are irrelevant.
- Rule 8 -The careful application of terror is also a form of communication.
- Rule 9 -You don't have to hit a home run to score. A bunch of singles will do the job just as well.
- Rule10 - Never wrestle with a pig; you both get dirty, and the pig likes it.

Sample Patient Survey Form

Thank you for choosing Rocky Mountain Neurosurgical Alliance for your medical care. Please help in our continued effort to provide you with the best medical care by taking just a few moments of your time to complete this questionnaire by indicating your response.

Please rate categories by: N/A = Not Applicable 1 = Excellent 2 = Very Good 3 = Good 4 = Fair 5 = Poor

SCHEDULING AND PRACTICE POLICY	N/A	1	2	3	4	5
Getting through to the office by phone						
How long you had to wait to get an appointment						
Convenience of the office location						
Length of time spent waiting at the office						
General appearance and cleanliness of the office						
Explanation regarding our billing policies						
Clarity of our patient information brochure						
PERSONNEL	N/A	1	2	3	4	5
Personal manner of the receptionist on the phone						
Friendliness and courteousness of the office staff						
Friendliness and courteousness of the billing staff						
Friendliness and courteousness of the nurses						
Efficiency of follow-up, test results, appointments, etc.						
Explanation regarding treatments and/or instructions						
Explanation of answers to questions you asked						
Time spent with the person you saw						
The personal manner, courtesy and sensitivity of the person you saw						
The technical skills, thoroughness and competence of the person you saw						
MEDICAL RESULTS	N/A	1	2	3	4	5
How helpful was the information/treatment you received?						
Do you continue to have pain? <input type="checkbox"/> Yes <input type="checkbox"/> No						
How would you judge improvement on your level of pain?						
Have you been able to return to your old job? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Has your job been modified for your condition? <input type="checkbox"/> Yes <input type="checkbox"/> No						
OVERALL IMPRESSION	N/A	1	2	3	4	5
The perceived value of service of care you received						
How well were your expectations met?						
Your overall impression of Rocky Mountain Neurosurgical Alliance						

THANK YOU FOR YOUR ASSISTANCE.

Additional comments or suggestions: _____

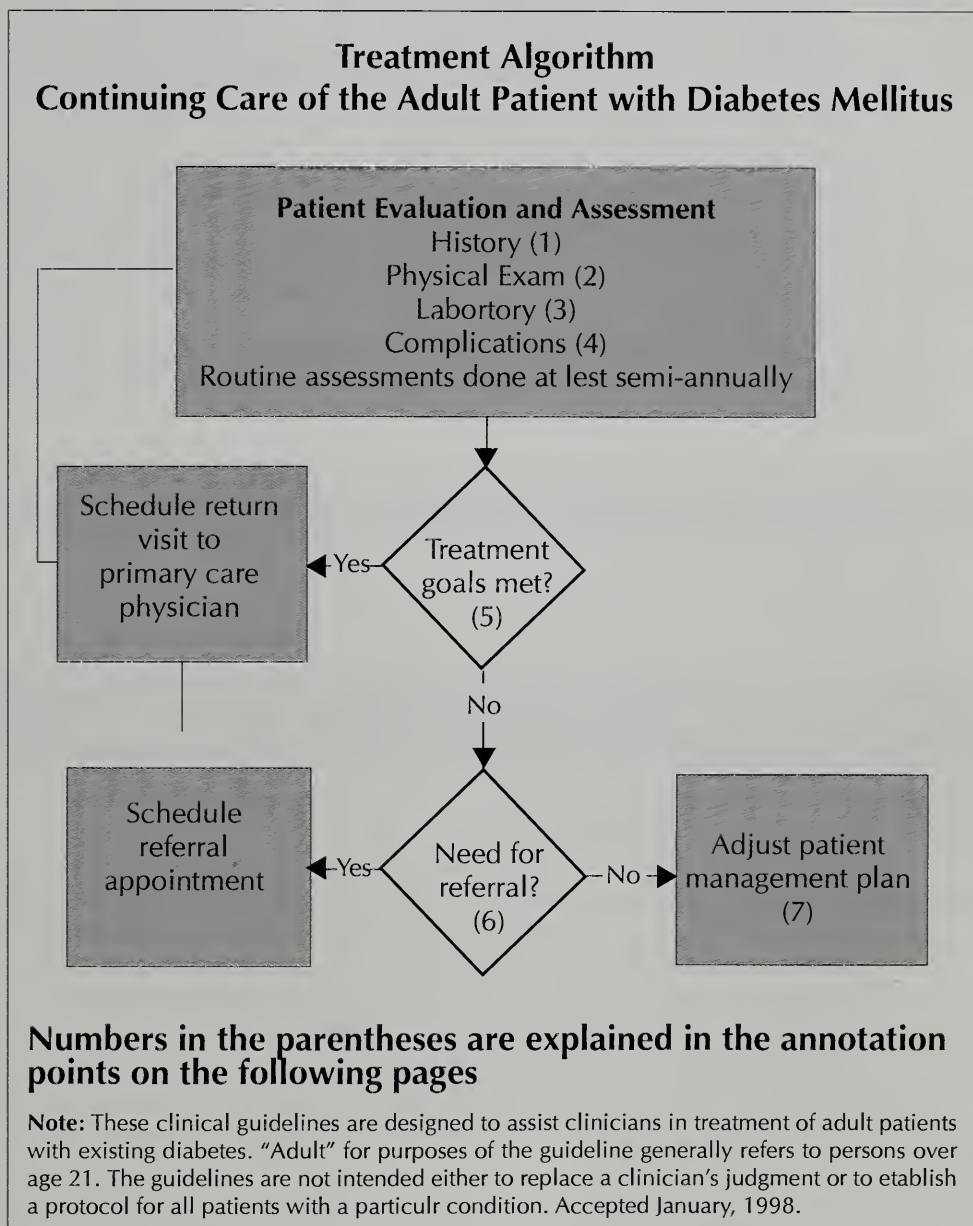
Diabetes Management

Long-term treatment goals for persons with diabetes include: (1) achieving near-normal metabolic control, (2) preventing or delaying long-term complications of diabetes and (3) assisting the patient with diabetes to lead a productive life.

A primary component of metabolic control is blood glucose control. It was demonstrated through the Diabetes Control and Complications Trial (DCCT) that in patients with type 1 diabetes, the development or progression of nephropathy, retinopathy and neuropathy was reduced 50% - 75% by using intensive insulin treatment regimens. In the group where benefits were observed, the patients had an average HbA_{1c} level of 7.2%. In a second study similar in design to the DCCT, patients with type 2 diabetes showed a comparable reduction in microvascular complications with similar glucose control. The following chart outlines blood glucose targets in non-pregnant patients with diabetes. Glycemic targets generally are set higher in patients with recurrent severe hypoglycemia, reduced awareness of hypoglycemic symptoms, advanced complications or co-existing disease, and the elderly. It is important to evaluate each patient with diabetes to develop individualized target glucose levels based on the patient's clinical status and the patient's willingness and ability to participate in his/her management of diabetes.

Colorado Clinical Guidelines Collaborative

Continuing Care of the Adult Patient with Diabetes Mellitus



BLOOD GLUCOSE GOALS IN NON-PREGNANT PATIENTS WITH DIABETES³

	Normal—non-diabetes values	Goal—patients with diabetes	Action suggested if **
Preprandial fasting glucose	<115 mg/dl	80-120 mg/dl	<80 or >140 mg/dl
2-hour postprandial	<140 mg/dl	<180 mg/d	<180 mg/dl
Bedtime glucose	<120 mg/dl	100-140 mg/dl	<100 or >160 mg/dl
<HbA _{1c} *	<6%	<7%	>8%

* Normal levels will vary by assay method (values based on normal range of 4%-6%)

** "Action suggested" depends on the individual patient. Actions may be changes in medication, provision of diabetes education or changes in self-management techniques.

Figure 1

¹ See reference 1.

² See reference 2.

³ See reference 3.

Approximate Comparison of Average Blood Glucose and HbA_{1c} Values

Glucose mg/dl									
60	90	120	150	180	210	240	270	300	330
↑	↑	↑	↑	↑	↑	↑	↑	↑	↑
↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
4	5	6	7	8	9	10	11	12	13

Figure 2 HbA_{1c} (based on normal range of 4%-6%)

Diabetes:

A chronic illness that requires continuing medical care and education to prevent acute complications and to reduce the risk of long-term complications.

The American Diabetes Association uses the following blood glucose values to define diabetes for diagnostic purposes:⁴

Normal: Fasting plasma glucose <110 mg/dl.

Impaired fasting glucose: Fasting plasma glucose ≥110 mg/dl and <126 mg/dl.

Impaired glucose tolerance: When results of oral glucose tolerance tests are ≥140 mg/dl but <200 mg/dl in a two-hour sample.

Diagnosis:⁵

A person is considered to have diabetes when one of the following diagnostic parameters are met.

Fasting plasma glucose ≥ 126 mg/dl (after no caloric intake for at least eight hours and no more than 14) or

A casual plasma glucose test level of ≥200 mg/dl taken at any time during the day without regard to the time of the last meal with the classic symptoms of increased urination, increased thirst and unexplained weight loss, or

An oral glucose tolerance test value of ≥200 mg/dl in the two-hour sample.

Note: Fasting plasma glucose is the preferred method of diagnosis and is advised to be used universally. The hemoglobin A1c test is not recommended for diagnosis, nor is the finger-prick test using a glucose meter.

Algorithm Annotations - These annotations refer to "numbers" on the Algorithm.

1&2 History and Physical Exam⁶

There are two levels of physical exam for the patient with diabetes. These include an annual comprehensive exam appropriate to the age and condition of the patient, and focused physical exams conducted between comprehensive annual exams. Areas of critical importance to include in the exam **specific to diabetes** are included below:

Diabetes-specific History areas to be included in all exams:

- * Patient's results of self-monitoring of blood glucose.
- * Problems adhering to treatment plan.
- * Patient changes in treatment regimen.
- * Frequency and causes of hypo- and hyperglycemia.
- * Acute complications.
- * Sick-day management.
- * Nutrition plan.
- * Exercise/activity plan.
- * Hypoglycemic unawareness.
- * Glucagon usage - in insulin-treated patients.
- * Current medications.
- * Contraception discussion and discussion of preconception glucose control in women of childbearing age.

Diabetes-specific elements in Physical Exams:

- * Foot exam, including touch sensation, pedal pulses, checking for ulcers and deformities. Besides this routine foot inspection, the annual exam should also include comprehensive vascular, neurological and musculoskeletal exam.
- * Annual dilated fundoscopic exam by eye care provider.

3. Laboratory⁷

- * HbA_{1c} at least semi-annually in patients with less than adequate glucose control, (defined by HbA_{1c} >8%) this is recommended **quarterly**.
- * Fasting lipid profile **annually** -- target goals for lipids are outlined below:

⁴ See reference 4.

⁵ See reference 4.

⁶ See references 3, 5, 6 and 7.

⁷ See references 3, 5, 6, 7, 8, 9, 10 and 11.

Lipid Profile Target Values

	Target Value (no CAD)	Target Value (CAD)
Total Cholesterol	<200 mg/dl	<200 mg/dl
Triglycerides	<200 mg/dl	<200 mg/dl
LDL cholesterol	<130 mg/dl	<100 mg/dl
HDL cholesterol	>35 mg/dl	>35 mg/dl

Figure 3

* Routine urinalysis performed **annually** —

* If urinalysis is **positive** for protein, a quantitative measure is needed to develop treatment plan.
(e.g., 24 hour urine collection for protein)

* If **not positive** for protein, microalbumin screening is recommended. Screening for microalbumin is generally done by one of two methods:

1. Measurement of the albumin/creatinine ratio in a spot collective of urine.
2. 24-hour urine collection for microalbumin with creatinine (allows for simultaneous measurement of creatinine clearance).

Note: If microalbumin positive, repeat twice within three months. If still positive, consider treatment with ACE inhibitors.

4. Complications⁸

- * **Hypertension:** Hypertension contributes to the development and progression of most chronic complications of diabetes.
- * The target goal for blood pressure in an adult with diabetes is 130/85 mm Hg or less.
- * ACE inhibitors are the drug of choice in most patients with diabetes.
- * **Nephropathy:** Maintaining near normoglycemia has been proven to delay the onset of microalbuminuria and delay the progression of microalbuminuria to clinical proteinuria in patients with diabetes.
 - * Decreasing blood pressure will delay the progression of diabetic nephropathy.
 - * ACE inhibitors use indicated with patients with positive protein (>300 mg/24 hrs.)
 - * Consideration should be given to the use of ACE inhibitors in patients with microalbuminuria even if normotensive. (Microalbuminuria defined as 30-300 mg/24 hrs.)
- * **Retinopathy:** An annual referral to an eye care specialist (optometrist or ophthalmologist) trained in management of diabetic eye disease is recommended.
 - * Refer patients with diagnosed diabetic eye disease to ophthalmologist experienced in the treatment of diabetic eye disease.
- * **Neuropathy:** There are three major types of neuropathy: distal symmetrical polyneuropathy, focal neuropathy, and autonomic neuropathy. Persons who develop neuropathy may or may not have the symptoms.
 - * Improvement in neuropathy may be seen with improved glucose control.
 - * Patients who have had a history of foot lesions or prior amputation require preventative foot care to avert recurrence of problems.
 - * Comprehensive vascular, neurological and musculoskeletal exams are important annually as are routine foot exams every time a person with diabetes is seen in the primary care setting.
 - * Educate all persons with diabetes about the risk for and prevention of foot problems.
- * **Vascular disease:** Diabetes causes both large and small vascular complications.
 - * Patients with diabetes are at increased risk for cardiovascular disease. Careful attention to modifying risk factors is suggested.
 - * Recommend cessation of smoking to all persons with diabetes.
- * **Diabetes and Pregnancy:** To prevent early pregnancy loss and decrease risk of congenital malformations, optimal diabetes control must begin prior to pregnancy. Prior to conception, the following is recommended:
 - * Optimize glycemic control to fall within the normal HbA1c range.
 - * Obtain baseline measure of all complications, including renal function and retinal status.
 - * Institute intensive insulin therapy.

⁸ See references 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15.

DIABETES CARE FLOW SHEET

Recommended Visit Schedule:

Patients meeting treatment goals—Semi-Annually
More often if: (1) patient unstable, (2) newly diagnosed, or (3) not meeting treatment goals

Enter results or date as appropriate on flow sheet

Area	Recommended frequency	Date	Date	Date	Date
Physical Findings (multiple Algorithm annotations—see footnote#)					
History and physical ^{1 & 2}	Comprehensive 1x annually. Focused at other visits				
Weight ^{1 & 2} Goal is BMI <27	Every visit				
Blood pressure ⁴ - goal is ≤130/85	Every visit				
Dilated eye exam referral ⁴	Annually				
Foot exam— ⁴					
• Sensation, pedal pulses, deformities, ulcers, color	Every visit				
• Comprehensive vascular, neurological and musculoskeletal	Annually				
Laboratory Tests (Algorithm annotation #3)					
HbA1c Depends on age, physical condition of patient. Evaluate Rxplan when >8%	2x annually — more often when not meeting treatment goals				
Urinalysis	Annually				
Microalbumin - if urine negative for protein	Annually—if positive, repeat test within 3 months				
• Urine albumin/creatinine ratio in a random spot-check					
• 24-hour collection with creatinine clearance					
Blood lipids	Annually				
• Cholesterol <200 mg/dl					
• Triglycerides <200 mg/dl					
• LDL ≤130 mg/dl (<100 with CAD)					
• HDL >35 mg/dl					
Diabetes Management Plan (Algorithm annotations #5)					
• Self blood glucose monitoring results	Every visit with comprehensive review annually				
• Nutrition					
• Exercise/physical activity					
• Compliance					
Preventive Care/Lifestyle (Algorithm annotation #4)					
Pneumococcal	At least one time				
Influenza vaccine	Annually				
Smoking cessation	Every visit				
Pregnancy counseling (women of childbearing age)	Every visit				
Referrals (Algorithm annotation #6)					
Diabetes Education, Endocrinologist, Diabetologist, Other specialists	As indicated				

#Superscript notations refer to number of Algorithm found in Guideline Document

* *Routine immunizations*

- * Annual influenza immunization.
- * Pneumococcal vaccine according to recommended guidelines (one dose).

5. Treatment Goals⁹

Long-term treatment goals for persons with diabetes include achieving near-normal metabolic control, preventing or delaying long-term complications and living a productive life. Helping a patient set achievable short-term goals is helpful in encouraging patients to work toward a more ambitious long-term goal. Working with the patient to set treatment goals in the following areas is encouraged:

- * *Glycemic control:* Both HbA1c levels and self blood glucose monitoring levels are important. The optimum HbA1c is <7%. The use of routine self-testing for glucose can assist the patient in glucose pattern recognition and improve his/her ability to alter daily activities to improve glucose control.
- * *Exercise:* Any improvement in activity will improve diabetes management, since exercise improves glucose control. It enhances insulin sensitivity, assists with weight reduction and reduces cardiovascular risk. Appropriate frequency and intensity of exercise depends on the patient's physical condition and presence or absence of complications of diabetes. Working towards exercising 3 - 4 times per week for 20 - 45 minutes is a desirable goal.
- * *Nutrition:* The overall goals of nutrition therapy in patients with diabetes are to provide adequate calories for maintenance of desired body mass index (BMI) and to promote overall health. Several meal-planning systems are available to choose from, including: exchange diet planning, general nutrition guidelines encompassed in the "food pyramid" system, and carbohydrate counting.
- * *Weight reduction:* Many patients with diabetes will never reach their ideal body weight. Any loss of weight will be useful in the management of their diabetes. Encouraging gradual lifestyle changes may be more effective than expecting rapid results.

6. Specialty Referrals¹⁰

A "team" approach to managing diabetes is helpful. Listed below are the most commonly used specialists available to assist the primary care physician in management of patients with diabetes:

- * *Eye Care Specialists:* In Colorado this is defined as an optometrist or ophthalmologist trained in management of diabetic eye disease. Common referrals include:
 - * Annual referral for all adults for eye exams.
 - * Referral to ophthalmologist experienced in treatment of diabetic eye disease for treatment of same.
- * *Endocrinologist/Diabetologist:* Common reasons for referral to endocrinologist/diabetologist include the following:
 - * Persistent inability to reach target glucose goals.
 - * Preconception counseling and glucose regulation prior to pregnancy.
 - * Persistent medication and/or treatment regimen failure.
 - * Intensive insulin or insulin pump therapy.
- * *Foot Care Specialist:* Common reasons for referral include:
 - * When patient is unable to care for his/her own feet properly.
 - * For preventive care when person has already had amputation or ulcerations.
 - * For specific problems such as deformities (e.g., Charcot foot), infected lesions, ulcers, deformed nails, thick calluses.
- * *Diabetes Educator (nurse or dietician, CDE preferred):* Common reasons for referral include:
 - * New diagnosis of diabetes.
 - * Change in treatment regimen, i.e., switching from oral meds to insulin.
 - * When patient having trouble maintaining treatment plan specifically in the areas of medication management, self-care skills such as monitoring, routine foot care, nutrition, exercise, sick-day rules, management of acute complications.
- * *Mental Health Specialist:* Common reasons for referral include:
 - * When patient having difficulty adjusting to diagnosis or treatment regimen.
 - * When underlying condition interferes with diabetes management.

7. Adjusting the Patient Management Plan¹¹

- * Encourage patients with diabetes to become actively involved in adjusting their diabetes management plan. An important role of the primary care physician in managing patients with diabetes is to help the patient to develop self-management skills. A physician/patient prepared management plan with target glucose goals is recommended. Encourage short-term goals to reach long-term objectives.
- * Therapy for the patient can be individualized utilizing both lifestyle changes and medication therapies to control diabetes. Examples of common medication therapies include single or combination oral therapy, combination oral and insulin therapy, or intensive insulin therapy.

¹⁰ & ¹¹ See references 3, 5 and 6.

Continuing Care of the Adult Patient with Diabetes Mellitus

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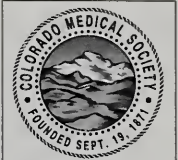
Acknowledgments

These guidelines have been compiled and recommended by the Advisory panel appointed by the Colorado Clinical Guidelines Collaborative.

Connie Feters, MHS, RN, CDE, chair
Daniel Besessen, MD
Donald A. Daeke, MD
Stanley J. Kerstein, MD, FACP
Jean Kutner, MD
Mark Levine, MD
Susan Sherman, MD
Helen Stover, RN, CDE

Members of the committee represent the Diabetes Advisory Council of the Colorado Department of Public Health and Environment, American Diabetes Association, Rocky Mountain Association of Diabetes Educators, Colorado Endocrinology Association, Colorado Medical Society, Colorado HMO Association, University of Colorado Health Sciences Center and physician practice groups.

Numerous other health care professionals in Colorado have also participated in the development of these guidelines through review and recommendations.



Starcraft, Leechlore and Wort-Cunning

by Seymour E. Wheelock, MD

With my trilby pulled down to cover my face, I sneaked into a nearby friendly health food emporium for a crock of cholesterol-free peanut butter and my weekly rose-hip fix. The proprietress, a powerful Katinka type of commanding mien, took note of my limp and I whined to her briefly about my painful knees.

"Not to worry," said she, exuding maternal solicitude. "When my back flares up I just take this (indicating with a flourish an imposing jar filled with an aggressive green powder). It will have you right as a trivet in jig time."

"What is it?" I inquired suspiciously.

"Why, it's our fastest-selling item, nature's source of lifetime health, vitality and well-being -- Green Barley Essence (G.B.E.), the Ideal Health Food."

It seems that Dr. Yoshihide Hagiwara (Kumamoto University Medical School '48), while amassing a fortune in the Japanese pharmaceutical industry, ignored his diet, and exposure to laboratory chemicals destroyed his health and part of his reasoning ability. In desperation, he abandoned "modern medicine" and began a regimen of a "natural diet", combined with an assortment of Chinese herbs. "He discovered the ideal combination of nutritive elements plus chlorophyll in the juice squeezed from the immature embryonic leaves of the barley plant." He called this material "Green Barley Essence - G.B.E."

Dr. Hagiwara indicates to us that "illnesses are indicated by an imbalance of minerals, enzymes,

and vitamins." Cure of disease followed from "a commitment to mental and physical habits which contribute to good health and the healing process..." -- plus Green Barley Essence!

My evangelistic informant thrust upon me an incredible (in the truest sense) book entitled *Green Barley Essence -- the Ideal Fast Food* and a giant jar of the product, a viridian dust with an earthy smell like an alfalfa field after a summer shower.

Testimonials abound in the 150 page book, a bulging granary of hard-sell misconception and garbled pseudo-scientific information.

Several effusive letters from adolescents profess their wonder at being cured of asthma, pimples, constipation, emotional instability and diabetes. Diabetes, we are told, particularly in infancy and childhood, is caused by acidification of the blood. Insulin levels in juvenile diabetes are "actually high, not low", but acid blood renders insulin "weak". G.B.E. alkalizes the blood and voila! - no diabetes.

Many are the disordered physiological processes set to rights by G.B.E.; the cornucopia of health is overflowing. The treatment of human ills with leaves, weeds and seeds is as ancient as mankind.

I own numerous forlorn home-made booklets constructed of faded purple paper stitched together with linen thread. (In the first half of the 19th century loaf sugar came wrapped in purple paper and paper was scarce. This fact also accounts for the purple color of many home-made cloth articles of that time; the dye in the wrapper was water-

Etditor's Note: Colorado Medical Society Historian John L. Lightburn, MD, is on vacation this month, and Dr. Wheelock, a trusted archival storyteller, has provided us with this month's look at medical practice of another era.

soluble and when mixed with a mordant gave linens and woolens a distinctive hue.)

These booklets contain handwritten formulations gleaned from anecdotal experience or items clipped from newspapers or an occasional Harper's Weekly, all evidence of desperation in the juvenile sick room of the New England of long ago.

"Cure for the bloody diarrhea: take white oak bark newly peeled from the tree, as much as you can hold between the thumbs and fingers of both hands, boil in a quart of water for a short time, etc."

"For the affections of the joints in children:

Burdock - 28 sound roots

Dandelion - 2 handfuls

Pennyroyal - 2 ounces

Boil in 1/2 gallon of soft water and give one gill in the morning, 1/2 a gill at night."

(Continued next page)

Sandwiched in between a recipe "to kill Flies in the Cheese Room" and "for the Sting of an Adder" is a sure cure for the croup: "Roast a yellow onion, mix its juice with honey, and give a teaspoon every 15 minutes until your child is relieved."

For hoarseness "take one drachm of horseradish, etc." For whooping cough: "take one ounce of Rhubarb, one drachm of English saffron, 1 1/2 drachm of cardamom seed, stir into molasses and give 1/2 teaspoon to a child 5 years old, 1/2 the quantity to an infant."

A poultice of onions was sure cure for the bite of mad dog - and on and on. But what else could they do? Pencillin was a remote century in the future.

In January 1856, the English Parliament directed a study be made and publication underwritten "for the history of this country from the invasion of the Romans to the reign of King Henry the Eighth." This was done, and the area of the healing arts became the exclusive desmayne of the Reverend Oswald Cockayne, MA, Cantab, who completed his three-volume work "History of Medical Science in this Country before the Norman Conquest in 1066", seven laborious years later and entitled it "Leechdoms".

Cockayne was a natural for the exacting job of peering into the realities of an era about which most of us could write only an anemic paragraph. The good Reverend was facile with Greek, Latin, Saxon, and t but he was not devoid of humor and insight.

"It will be difficult," he begins, "for the kindest temper to give friendly welcome to the Medical Philosophy of Saxon days. From the cradle, modern Englishmen are taught to fight an angry battle against superstition, and they treat a talisman or charm with some disdain and much contempt. But let us reflect that these playthings tended to quiet and reassure the Saxon patient, to calm his temper and sooth his nerves. Let the reader

remember that the dread of death and wakeful anxiety must be hushed by some means, for they are very friendly to recovery from disease. Particularly is this true for the wailing child."

Cockayne then described an agrarian primitive culture with few refinements, appalled by the savage and chimeric elements that raged unpredictably about it. "The Church," says he, "held the Saxons in slavery with its numerous medical masses and the interminable blessing of the worts (herbs and other plants) in the field but it had delivered them from a worse servitude than this; from the tyranny and terror of the poisoner and the wizard."

The pages of volume one of "Leechdoms" detail in scholarly precision the *materia medica* of that despairing time. There was a botanical to cure any and all disorders, and the leeches of the day learned what Greek and Latin they could and plundered the classic literature of their own (now extraordinarily rare) texts. For a modern botanist, Saxon botany was confused and confusing, including many plants never yet identified. But there were some old favorites, e.g. mandrake, the penicillin of its day. "Knocked" (ground), eaten, or placed under one's pallet, it was excellent for: "headaches, sores of ears, foot disease, loss of wits, sore child be seized by worms."

Volumes two and three are filled with simple to elaborate leechdoms, the ritualistic mechanisms for warding off impending disaster, modifying a calamity already endured or changing the natural course of events.

For example, the "half-dead disease" (hemiplegia) was caused by "evil, slippery and thick humours" which must be removed by bloodletting, draughts, and specific leechdoms. "In order that a woman may kindle a male child," intones the ancient writing, "dry a hare's belly and cut in half and let man and wife both eat. If she alone eats, she will kindle a child neither man nor woman." (Our endocrinologist friends may be missing something!)

Perinatology had its secular mysteries as well. Witness the following alternatives to paracentesis in forecasting fetal sex and and congenital defect prior to birth: "Again there is another method about these matters that you may know about a pregnant woman, of whether sex she is to bear a child. Take two worts in hand, namely lily and rose, carry them to a pregnant woman, bid her take whether she chooses of those worts; if she takes a lily, she will bear a boy, if she takes a rose she will bring forth a girl."

It is easy to trace some of these bizarre leechdoms across 800 to 900 years to our own day by simply contemplating Tom Sawyer's knowledge of leechlore in the case of wart removal:

"You got to go all by yourself to the middle of the woods where you know there's a spunk-water stump (rain-water in a hollow stump) and just as it's midnight you back up against the stump, jam your hand in and say 'Barley-corn, barley-corn, injun-meal shorts. Spunk-water, spunk-water, swaller these warts.' Then walk away quick, eleven steps with your eyes shut and turn around three times and walk home without speaking to anybody. Because if you speak the charm's busted."

Right out of volume three that was.

Yet, the extensive and singular use in that simpler day of a vast *materia medica* had ponderous official sanction. In 1820, in an effort to bring order out of botanical and pharmaceutical chaos, a "General convention for the formation of the American Pharmacopoeia" was held in Philadelphia. The nation was divided into four "grand divisions", each represented by well-known and respected physicians of that time. The Eastern Grand Division, for example, was headed by Eli Ives, MD, lecturer in pediatric diseases at Yale, some of whose scholarly deliverances repose in the Waring Room at UCHSC. (The Yale medical student who took these notes was Joseph Adam Denison of Vermont, grandfather of Drs. Charles and

(Continued)

Henry Denison, for whom the UCHSC medical library is named.) The result of the sober deliberations of these several bodies was published and distributed widely, with the reassurance that it would be republished with "additions and corrections" in ten years - and so it was.

There appears to be no limit to the relentless dark undercurrents of gullibility in so-called sophisticated societies. The sale of "Green Barley Essence" is apparently a multi-million dollar industry in Japan, the United States, Europe and Australia. There is an "Association of Green and Health" whose only code is "Partake abundantly of vegetables having deep green colors," and whose spiritual leader is SHIN-HUANG-ti, who in the Chin era of China "compiled the fundamentals of Chinese medicine": "It is diet which maintains true health and becomes the best drug."

So--if you are bitten by a toad, don't call me because I'm all out of the sovereign remedy yellow saxifrage, but if you are troubled by "mickel hicket" (profuse hiccups) brought on by "the taking of gruel grievous hot into the maw," then I'm your leech, because it won't take a minute to boil up "the claws of a spotted ferret in the milk of an ass, milked with the right hand only." My good wife gets "mickle hicket" after passing hot Sanka down her maw - every time - and when she does, the pages of a venerable formulary, constructed of aignellinus by unknown and ancient hands, rustle slightly.

As for me, I take my G.B.E. twice a day in O.J. The only side reaction noticed is a distressing tendency lately to nip off a succulent new leaf from our crabapple tree now and again - but at least my knees are turning green.

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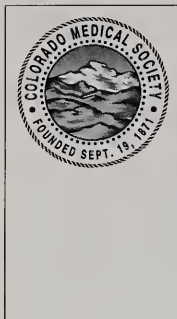
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Colorado Medical Society



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(Continued next page)

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Highlights of Board of Directors Meeting - March 13, 1998

- A. **Copic:** Dr. Jerry Buckley reported that Copic is in the best financial shape it has ever been in. At the House of Delegates General Membership tomorrow, Dr. Buckley presented what California is doing with physician profiles, and what they have included on the Internet. He also reported that Copic has discovered a way to do business outside the Colorado state borders.
- B. **CMSA:** Ms. Stella Shanks stated that she would present her end-of-the year report at the House of Delegates. She thanked the Board for their continued support of the Alliance.
- C. **AMA Delegation:** Dr. Richert Quinn reported on the AMA Leadership Conference held recently in Washington, DC. He felt that it was an outstanding meeting. President Clinton and General Colin Powell were two of the speakers. He also attended a program on fraud and abuse.
- Dr. Jeremy Lazarus presented a statement from the Colorado Board of Medical Examiners concerning the physician/patient relationship.
- D. **Colorado Physician Network (CPN):** Dr. David Martz thanked the Board for the approval to speak at the General Membership Meeting. He stated that Rocky Mountain HMO reported losses in the 1996 and the first two quarters of 1997. Rocky Mountain HMO has recently hired new key staff people to market Rocky Mountain Physician's Choice, with the Denver Metro area targeted for September 1, 1998. Dr. Martz stated that CPN now has 5,600 enrollees.
- E. **Colorado Rural Outreach Program (CROP):** Dr. Jack Berry stated that he would present a complete report at the General Membership Meeting. He stated that proposals totaling over one million dollars have been sent out, and so far they have received grants totaling \$130,000. The Colorado Medical Society Foundation created a document regarding support of diversification, which was distributed to the Board.

The next Board Meeting will be held on May 1, 1998, at the Sonnenalp Resort in Vail CO.

CALL FOR NOMINATIONS 1998 Wyeth-Ayerst Physician Award for Community Service

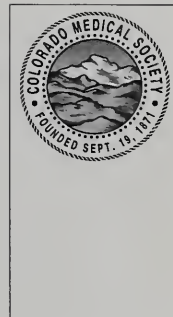
The Colorado Medical Society is pleased to announce that once again the Society will be cooperating with Wyeth-Ayerst Laboratories in presenting the 1998 Physician Award for Community Service. This is an opportunity for you, CMS members, to honor one of your fellows who has contributed in an outstanding way to his or her community. The criteria are simple, as follows:

- The recipient must be a physician licensed within Colorado.
- The recipient must be living; no posthumous awards are permitted.
- The recipient may not have received this award previously.
- The recipient has completed an outstanding record of community service which reflects well on the physician.

Each nomination made must be accompanied by a personal data sheet describing the nominee's community work. Supporting documents (testimonial letters and statements, published data, etc.) should also accompany the nomination. None of the materials will be returned.

Nominations must be received by June 1, 1998. It is very important that **all nominations and supporting material be mailed to the following address:**

**Confidential Awards Committee
Colorado Medical Society
P. O. Box 17550
Denver, CO 80217-0550**



Proceedings of the House of Delegates - Interim Meeting, 1998

The Colorado Medical Society House of Delegates met at the Denver Marriott Southeast, Denver, Colorado, March 14-15, 1998, and took the following actions:

REFERENCE COMMITTEE OF THE 1998 INTERIM MEETING

Adopted a resolution encouraging physicians to inquire about the use of alternative or unconventional therapies by their patients, and to encourage scientific research to evaluate the efficacy of alternative therapies.

Adopted a resolution requesting the Colorado Medical Society attempt to not conflict with Spring breaks when planning its Interim Meetings, and to consider the needs of the delegates' families when choosing an Annual Meeting site.

Adopted a resolution requesting the Colorado Medical Society to arrange a candidates' reception at the Annual Meetings, and to continue presentations by the candidates at the opening session of the House of Delegates.

Adopted a resolution calling for a committee or task force to develop public and/or school campaigns to educate society on the dangers of drinking and driving and to create and pass legislation to lower the legal Driving Under the Influence (DUI) blood alcohol level to 0.08% or less.

Adopted a resolution calling for a feasibility study to look at adding physician profiles and a list of physician participation in insurance/HMO plans to the Colorado Medical Society Web Site for Consumers. The study should include the cost for maintaining current and accurate data.

Adopted a resolution changing the name of the "Necrology Report" to "In Memoriam".

Adopted a resolution approving the "Hassle Factor Project", which will log problems physicians' offices experience with third party payers. The resolution also calls for this information to be shared with the state insurance commissioner.

Adopted a resolution to continue financial support to Colorado Rural Outreach Program (CROP) until reevaluation is made by the Board of Directors and the Finance Committee.

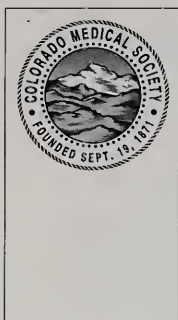
Adopted a resolution calling for the Colorado Medical Society to condemn the practice of female genital mutilation as defined by the American College of Obstetrics and Gynecology as a medically inappropriate procedure with no scientific basis. This resolution also calls for the Colorado Medical Society to consider female genital mutilation a form of physical abuse.

Adopted a resolution requesting the Colorado Medical Society support a policy for provider disciplinary actions under Workers' Compensation utilization review, to include 1) peer review of all clinical issues, 2) an opportunity for providers to present their cases, present additional information, and answer questions, and 3) provide at least two (2) levels of appeal.

Adopted a resolution to reaffirm the Colorado Medical Society's policy on "Termination without Cause", and to add an appeal process to an external, independent panel as a form of due process protection.

Accepted for filing:

- Progress Report - Colorado AMA Delegation
- Progress Report - Board of Directors
- Progress Report - Executive Director
- Progress Report - Council on Legislation
- Progress Report - Health Affairs Council



INTERIM MEETING 1998

Attendees to the House of Delegates Interim Meeting 1998

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Ellen M Burkett, MD
Richard B Capek Jr, MD
Robert B Culberson, MD
James R DeLine, MD
Joseph Y Dwoskin, MD
Nancy J Germer, MD
Steven J Gulevich, MD
Allan B Kortz, MD
George M Kreye, MD
Mark A Levine, MD
M Herzl Melmed, MD
Peter I Monheit, MD
Michael P O'Leary, MD
Gary L Post, MD
David P Schreiber, MD
Brian R Smith, MD
Richard H Stienmier, MD
Eric S Weinstein, MD
Clara L Winter, MD

Aurora-Adams County

Roderic D Gottula, MD
Angeline D Heaton, MD
Carl E Heaton, MD
Renu Jalota, MD
Aurora-
Miguel A Morales, MD
Robert A O'Dell, MD
John D Rich, MD
Harry S Spaulding Jr, MD
Barry R Sundland, MD
Christopher J Unrein, DO
Paul B Visconti, MD

Boulder County

Jan F Baumgardner, MD
Alan E Benson, MD
Kevin R Berg, MD
Gene E Bolles, MD
John O Cletcher Jr, MD
William S Curtis, MD
Mary E Faini, MD
Severance B Kelley, MD
Herbert S Mooney Jr, MD
Scott L Replogle, MD
Gerald R Rupp, MD
John R Steinbaugh, MD
Patrick L Wherry, MD
Vernon E Zurick, MD

Clear Creek Valley

Richard L Brundige, MD
Chester M Cedars, MD
Richard S Cohen, MD
William L Doig, MD
Gordon H Fleischaker Jr, MD

Fred Grossman, MD
Philip M Henbest, DO
Joel M Karlin, MD
Jan M Kief, MD
Charles W Mains, MD
Howard E Netz, MD
Walter H Oppenheim, MD
Lynn Parry, MD
Ronald E Tegtmeier, MD

Colo. Chap. Amer. College of Emergency Physicians

Carla E Murphy, DO

Colorado Child & Adoles- cent Psychiatric Society

Irvin A Ebaugh Jr, MD

Curecanti

Lynwood M Hopple, MD

Denver

Richard Allen, MD
Richard F Bakemeier, MD
Hirsh E Barmatz, MD
D G Butterfield, MD
David N Campbell, MD
John E Delauro, MD
Richard P Evans, MD
Donald W Fink, MD
Glenn T Foust III, MD
Joy L Hawkins, MD
David E Hutchison, MD
Eugene D Jacobson, MD
George E Kandel, MD
David L Kelble, MD
Jeannie J Kinzie, MD
Frank J Major, MD
Bonnie McCafferty, MD
Michael Muftic, MD
Nancy E Nelson, MD
W Gerald Rainer, MD
Erick R Ratzer, MD
James R Regan, MD
Carol M Rumack, MD

Denver (Continued)

Robert B Sawyer, MD
Richard L Stieg, MD
Del Stigler, MD
Denver
Terrance J Sullivan, MD
Heidi W Tessler, MD
Louise D Converse Walker, MD

El Paso County

Francis J Barry, MD
John D Burrington, MD
Lewis A Crawford, MD
William E Emeis, MD
David C Martz, MD
Larry A Moore, MD
John B Muth, MD
Robert T Pero, MD
Joseph S Pollard Jr, MD
A Thomen Reece, MD
James J Simerville, MD
Teresa H Struck, MD
Paul M Wall, MD

Fremont County

Peter J Gamache, MD

IMG Section

Velusamy Kailasam, MD

Larimer County

Thomas J Allen, MD
Bruce R Belleville, MD
Cory D Carroll, MD
Edward J Donner, MD
Robert H Ellis, MD
A Bill Kieger, MD
Robert J Stuart, MD
Robert J Tello, MD
Steven J Thorson, MD
P K Vedanthan, MD

Las Animas County

Douglas M McFarland, MD

Medical Student

Ryan A Aukerman
Robert A Brockmann
Daniel A Langer

Mesa County

Lee B Golter, MD
Richard A Moore, MD
Theodore R Sadler Jr, MD
Patrick A Sillix, DO
Frederic B Walker IV, MD

Mt. Sopris County

Ronal B Mason, MD

Northeast Colorado

Joseph E Bonelli, MD, PhD

Pueblo County

Robert L Drake, MD
Thomas K Gaide, MD
Alan G Herrington, MD
Alethia E Morgan, MD
Sharon K Schaefer, MD
Robert E Tonsing, MD
James R Valenzuela, MD

San Luis Valley

Richard L Brownrigg, MD
Michael G Firth, MD

Washington-Yuma County

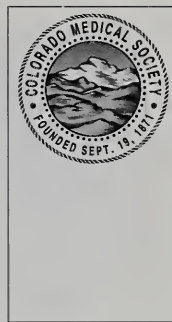
Mark E Hubner, MD

Weld County

Richert E Quinn Jr, MD
Roy H Shore, MD

Women In Medicine Section

Sarah B VanScoy, MD



*Stella Shanks, President
Colorado Medical Society Alliance
1987-1988*

CMS Alliance Supports Medical Education - Plans Future Events

CMS Alliance Year End Report 1997 - 1998

Despite a decline in membership this year, my report will show that the members we have are working and contributing in an outstanding way.

Legislation - We have distributed CMS Legislative digests and rosters to all counties and kept them current on health-related legislation. We have communicated with our national legislation committee and kept them informed about legislation in Colorado. We also took part in Legislative alerts. On March 2nd, we had another outstanding Day at the Capitol, with a large turnout. Thank you all who attended and made this educational day a success.

AMA Education Research Foundation - \$14,708 has been contributed so far this year. Sharing cards have been our greatest success, with a total of \$12,455 being contributed by Longmont, Mesa, Metro-Denver and Pueblo Alliances. Pueblo receives the greatest contribution award, and Longmont the greatest contribution per member award. Congratulations to both.

Emergency Benevolent Fund - Was established in 1942 in order to provide funds for CMS members and their families if they had emergency financial needs. All requests are held in strict confidence and all money given from this fund is considered a gift to the recipient and does not have to be reimbursed. This fund has had no activity for some years.

I will now briefly highlight some of the work that was accomplished by each county:

Boulder - members support Boulder charities which include: Child and Family Advocacy Center, the Virgil Grillo Health Resource Center, and Bright Beginnings and Warm Welcomes. They funded these from the proceeds of their Progressive Dinner and from their Spring Charity Ball, which will be held on April 18th.

El Paso - "Their Year of Discovery" focused on practical and educational efforts on attacking Family Violence. Their members participated in fundraisers for the Center for the Prevention of Domestic Violence, as well as donating needed supplies on a monthly basis. They support Court Appointed Special Advocates (CASA). They have planned an extravaganza with Sak's Fifth Avenue to be held at the Broadmore International Center on April 22. They are optimistic that they will sell the 800 seats because the beneficiaries will be the Lillian Morrison Memorial Scholarship Fund - which provides financial assistance to students seeking careers in any medical fields - and the Family Violence projects.

Larimer - Sponsored two seminars which they opened to the community. The first in October by Dr. Bernie Siegel, on the role of one's attitude on fighting cancer. The second in February by Dr. Jean Beyer on Woman's Life issues. Both of these were sell-out events. They had a successful "non-event" catalogue sale which raised \$5000 for their health projects.

Longmont - Continues their Blood Drives, every other month, drawing 100 - 120 donors. They also support AMA-ERF and through personal donations, provide scholarships to students seeking a career in medicine. This year's recipient will be awarded \$1500.

Mesa - Continued their focus on SAVE (Stop America's Violence Everywhere), by co-sponsoring a Courthouse Vigil in October, by purchasing billboards, and by distributing "I Can Choose" books to first-graders. They contributed \$5000 to the Western Slope Center for Children, in order to furnish the examining room. They accomplished this through their annual Progressive Dinner with matching funds from the Mesa Medical Society.

Metro-Denver (Includes Arapahoe, Aurora, Clear Creek and Denver counties) - Doctor's Day celebrations are scheduled for March 28th and included a dinner, silent auction and dancing. The proceeds from this will be used to purchase infant simulators called "Baby Think It Over". These dolls are distributed to teenagers in schools to help them understand the realities of having a baby to care for, and it is the hope that this experience will decrease teen pregnancies and prevent child abuse. Their second planned event for April 18th is a luncheon/fashion show, and the proceeds from this will also fund "Baby Think It Over" dolls. In support of SAVE day in October, they purchased and planted a tree at the State Capitol, in memory of victims of domestic violence.

(Continued next page)

CMS ALLIANCE (Continued)

Montrose - Their long-standing tradition of providing scholarships to students seeking medical careers continues with \$3,000.00 being awarded this year to four applicants. They provide the volunteers and organizational skills to make "Fall Clinics" in Montrose a continuing success. This is an educational weekend for doctors and nurses, complete with CMEs. They are in the process of starting a much-needed program in their area, an infant/toddler car seat sales program. Also, they donated \$1500 to Hospice and the Rainbow Center as part of their Special Projects program.

Pueblo - Had yet another successful Bronco Party, the proceeds going towards the purchase of 1900 "I Can Choose" Books for School Districts 60 & 70. \$1000 also was donated to the YWCA for the Victims of Abuse Shelter. They continue their support of AMA-ERF.

Otero - Members continue support of the Arkansas Valley Resource Center, provide the Safe House with needed items and cash contributions, support AMA-ERF, and use Organella as a teaching aid for kindergarteners. Because of the distances between locations of the towns making up Otero county, members work on individual needs in their various communities. Members are involved with the Home Health Agency and the American Cancer Society, while others coordinate Blood Drives.

N.B. The series of books referred to as "**I Can Choose**" are conflict resolution books for grades K-3. The books were the brainchild of Mary Hanson, El Paso county. Mary was President of the AMA Alliance in 1993.

Nominating Committee - is pleased to present the slate of officers for 1998 - 99 year.

Co-Presidents:

Sue Foerster, Leslie Nathan, El Paso.

President-elect:

Joyce Wilson, Metro Denver.

Secretary:

Linda Warren, El Paso

Treasurer:

Patti Ackley, Mesa

These officers were installed at this meeting.

Our Alliance is also well-represented at the national level with Patti Brown being promoted to the Chair of the AMAA Legislation Committee. I will serve as a member of the AMAA Membership Committee.

A sincere thank-you to Dr. VanderArk, the staff of the Colorado Medical Society, and all of you, for the great support you have given the Alliance this past year. We could not have done it without your support, both here and at home.

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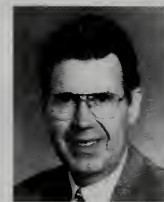
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HCCA, 655 Broadway, Denver, CO 80203.

Colorado Physician Network, Inc.



by David M. Martz, MD
President CPN

Good News--Bad News

"Ultimate Choice"

The past year has been one of **Good News and Bad News** for Rocky Mountain Physicians Choice (RMPC). We are currently almost a year behind our projected pace. We had planned implementation to be complete throughout the Front Range by now, and yet we've only just begun. The Bad News is that in 1996, our collaborative associate, Rocky Mountain HMO (RMHMO), experienced a \$3.8 Million loss after withholds. The Good News is that in 1997 the loss was only \$1.8 million! Medicaid lost \$2 million statewide, and \$2.5 million in Denver-Metro alone! We were forced to back off on aggressive expansion into the Front Range until the losses were corrected.

The truly Good News is that decisive measures have been initiated. Aspen and the Medicaid component of Roaring Fork, the areas of greatest loss, have been exited for the present. Medicaid in the Denver-Metro area has been significantly cut back, pending implementation of a reasonable stop loss ceiling for individual catastrophes and avoidance of adverse selection potential. The effect is already evident, with the last

2 quarters of 1997 profitable and the projections for 1998 overall to be profitable. Furthermore, we have created a task force to focus on the Denver Metro losses, clarify the causes and correct them urgently.

We are now revising our implementation sequence. RMHMO has recently hired several new high level staff members whose primary responsibility is to facilitate the growth and success of RMPC. A "SWAT team" approach of focused multidimensional staff involvement in one community at a time is now underway beginning now in the Greeley--Ft. Collins community. The Pueblo emphasis begins about June 1, then Colorado Springs around August 1, and Denver Metro near September 1. In addition, we are currently enhancing the Eastern Plains activities and working on large group employers in the Denver Metro area. RMHMO has been successful in getting the Division of Insurance to allow more flexibility in setting premiums for small employers. Previously they were forced to charge identical premiums in all counties under 20,000 population (placing, for example, Aspen and Wray in identical premium categories). As of July 1 this year we can rate adjust for the individual communities.

Best of all, a revolutionary new 3-tier product combining HMO, Point

of Service, and Indemnity-type options in a single policy is being prepared for marketing early this summer. We expect to be among the first in Colorado to offer this "Ultimate Choice" plan, giving us differentiation that is most consistent with our core values and has been most attractive to employers with whom it has been discussed already.

We also acknowledge that channels of communication for your concerns and feedback have not been adequate. Nor have we effectively disseminated up to date information to our members on a regular basis. Both of these shortcomings are being corrected.

Despite all the Bad News, RMPC already has about 5600 enrollees throughout the state. Our physician panel has grown by several hundred. And RMHMO was designated as best in the state by an independent consumer satisfaction survey this year! These are notable accomplishments in today's environment!

We hope this candid update on our status will clarify our situation for you. We **have had** a year with more Bad than Good News, but we hope and believe that the worst is now behind us. We expect the next 6 months to be more Good News than Bad News, and we will renew our efforts to keep you updated on a regular basis.

Have you tried the CMS web page yet? Dial in! You may well be surprised with the amount and worth of the information you find on the CMS home page.

www.cms.org

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The information about the costs of the card described in this advertisement is accurate as of 6/97. The information may have changed after that date. To find out what may have changed, call MBNA at 1-800-523-7666. TTY users, call 1-800-833-6262.

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ADG-5-3-97

ADG-NABA-59

AMA Solutions to Sponsor Entrepreneurship Seminar for Physicians

AMA Solutions, a subsidiary of the American Medical Association, is sponsoring a seminar,

Physician Entrepreneurship: Principles, Practices and Tactics for New Healthcare Ventures

WHO: Presented in conjunction with Northwestern University's Kellogg Graduate School of Management, focusing on business skills physicians need to be leaders in today's volatile healthcare market. Craig Samuels, the conference organizer, points out that "physicians are increasingly being asked to participate in capitation and other business arrangements which may put them at financial risk. As a result, physicians need a working understanding of business concepts to understand the implications of these ventures."

WHEN: May 17 - May 20, 1998

WHERE: "North Shore Doubletree Hotel in Skokie, Illinois

WHY: With the rapidly changing delivery of healthcare services in the United States, physicians are confronting new challenges that affect not only their financial viability but even basic survival.

For more information about the seminar, including registration fees and a complete conference program, call 800-366-6968 or visit www.amsolutions.com

1998 Colorado Medical Society President-elect's Planning Conference

April 30 - May 1, 1998 • Sonnenalp • Vail, Colorado



W. George Shanks, MD
President-elect 1998-1999
Colorado Medical Society

In early March I seized the opportunity to attend the AMA Leadership Conference in Washington D.C. Attendees heard from William Jefferson Clinton, Newt Gingrich, Ted Kennedy, Phil Graham, Antonin Scalia, Colin Powell and Nancy Ann DeParle (the head of the Health Care Financing Authority). Their message was that health care in the United States is a major problem, and they recognize that without our help they will have a difficult time solving it. As someone observed, "Today they are lining up at our door, when a few years ago we couldn't get their chauffeur to speak to us."

I see a window of opportunity open to us to significantly influence our future. There is no question in my mind that we have the answers within the CMS membership. I only pray that

we will take the time to ferret out the solutions and then present them with a unified voice.

As a first small step, the President-Elect's Planning Conference will take place in Vail on the first weekend in May. The program is printed in this issue of Colorado Medicine. On Saturday, we will discuss the implications of the new regulations regarding Fraud, Waste and Abuse. Hopefully we can get a better understanding of the impact of these regulations and their potential adverse effects upon our ability to deliver quality health care to our patients. I am concerned that the regulators will have a very narrow focus and we must make sure that they see the whole picture. At the same time, we must be careful that any criticism of the regulators is not perceived as

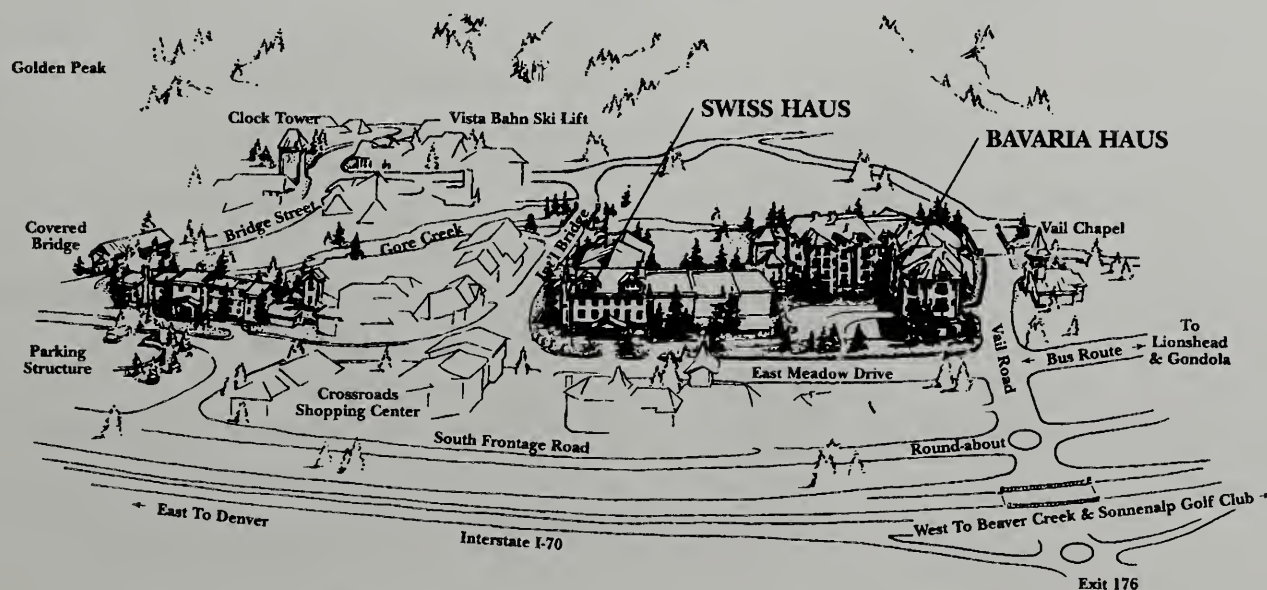
condoning Fraud, Waste and Abuse.

On Sunday, we will address the problem of managing Managed Care. We have fought vigorously against a government-run health care system in this country and encouraged the development of a market-driven system. One of the major drawbacks of wishing for something is actually getting it. If this system does not work, the only entity left to pick up the pieces is the Federal government. With the disgruntlement of just about everyone toward Managed Care, once again the window is open for us to have an impact.

The place is Vail on the first weekend in May. Please attend, and help us meet these great challenges and great opportunities.

W. George Shanks M.D.

To Sonnenalp in Vail Village



Colorado Medical Society
President-Elect's Planning Conference

May 2 - 3, 1998
Sonnenalp Resort, Vail
Registration Form

☐ I plan to attend the Leadership Conference to be held May 2-3 at the Sonnenalp Resort in Vail, including dinner on Saturday night.

My spouse/guest will attend the Conference and dinner on Saturday

☐ My spouse/guest will not attend the Conference but will come to dinner on Saturday night.

☐ Name: _____ Component Society: _____

Name of Spouse/Guest (if attending): _____

Mail to CMS, P O Box 17550, Denver, CO 80217
or Fax 303-771-8657

Sonnenalp Resort of Vail

Group Name: Colorado Medical Society

Name: _____ Phone #: () _____

Address: _____ City: _____

State: _____ Zip: _____ Number in Party _____

Arrival Date: _____ Departure Date: _____

Credit Card Information:

Please Note: A deposit equal to one night's stay will be charged to your credit card. Balance is due upon check-out.

Check one: ☐ Mastercard ☐ Visa ☐ Diners Club ☐ American Express

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Special Seminar/Conference rate will be extended to attendees for longer stays.

Desired Accommodations:-Bavaria Haus Suites: ☐ King Bed ☐ 2 Double Beds

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There will be an additional charge of \$25.00 per night for each person over 12 years of age exceeding Double occupancy.

(Note: most suite types cannot accommodate more than 3 adults.)

Reservations received after April 17, 1998, will be taken on a space available basis only.

Cancellation Policy: In the event of cancellation 14 or more days prior to arrival, you will receive a full refund. If you cancel less than 14 days prior to arrival, you will forfeit the deposit of one night room and tax.

Reservations will be taken with this form or call our reservations Department at (800) 654-8312.

Please mail this form to:

Sonnenalp Resort, Attn: Group Reservations, 20 Vail Road, Vail, CO 81657

Colorado Medical Society

President-Elect Planning Conference

May 2 - 3, 1998 • Sonnenalp Resort • Vail, Colorado

Where do *YOU* fit in? Where does *CMS* fit in?

1. Overall theme for the conference:
"The Medical Profession Under Seige"
2. The **Sonnenalp** has no space available on Friday night for a banquet. We will have the banquet on Saturday. Friday night would not have planned activities, except for the speakers and we will try to have a reception or dinner for the speakers. Following is a tentative daily schedule:

FRIDAY - May 1

1:00 to 2:00 p.m. Finance Committee
 2:00 to 5:00 p.m. Board of Directors
 Evening No planned activities

SATURDAY - May 2

Title: **"Trading Your Stethoscope for _____"**

- a) Hancuffs
- b) Paperwork
- c) FBI Spy Glass
- d) Compliance Manuals

7:00 am- 8:00 am **Breakfast**

8:00 am- 8:15 am **Opening Remarks by Dr. Shanks**

8:15 am- 8:45 am **"What is Fraud and Abuse"**

..... Lecture format

..... Potential presenters:

- Sandi Maloney and other CMS staff as presenters

8:45 am -10:15 am **"What are the Triggers to Fraud and Abuse?"**

..... Panel discussion with a moderator. Each panel member would be given

..... 15 minutes to speak with time at the end (30 minutes for questions and answers).

..... Panel Members could include:

- David Burlage, CMS Legal Counsel (confirmed)
- Maggi Cary, M.D., Region VIII Director of Health and Human Services
- Office of Inspector General or HCFA Program Integrity
- FBI Spokesperson

..... Moderator:

- ?

10:15 am - 10:30 am **Coffee Break**

10:30 am - 11:15 am **"Quest for Compliance"**

..... Lecture format with presentation on how to comply with a discussion on the
 AMA's Compliance Manual

..... Possible speaker:

- Carol O'Brien, JD from the AMA (confirmed)

11:15 am -12:15 pm **Keynote with Haavi Morreim** (confirmed)

12:15 pm **Closing remarks by Dr. Shanks**

12:30 pm **Adjournment** Afternoon open - no planned activities

6:00 pm - 6:30 pm **Cocktails**

6:30 pm - 7:30 pm **Dinner**

7:30 pm - 8:30 pm **Haavi Morreim - dinner speaker** (confirmed)

(Continued on following page)

Colorado Medical Society
President-Elect Planning Conference
 May 2 - 3, 1998 • Sonnenalp Resort • Vail, Colorado
Where do YOU fit in? Where does CMS fit in?

(Continued from preceding page)

SUNDAY - May 3

Title: **"Managing Managed Care"**

7:00 am - 8:00am **Breakfast**

8:00 am - 8:15 am **Opening Remarks by Dr. Shanks**

8:15 am - 9:15 am **"National Trends and What Makes a Model HMO Contract"** (Lecture format)
 Possible presenter:
 • Carol O'Brien, JD, AMA (confirmed)

9:15 am - 10:00 am **"What HMO's Want From Physicians"**
 Lecture format with two speakers (15 minutes each with short time for questions and answers)
 Possible speakers:
 • Mike Weber - Rocky Mountain HMO (confirmed)
 • Steve O'Dell - HMO Colorado (invited)

10:00 am - 10:15 am **Coffee Break**

10:15 am - 11:30 am **"Health Plans - Are They Measuring Up?"** (Panel discussion with a moderator)
 Each panel member would have 15 minutes to present and then there would be 15 minutes for questions and answers.
 Possible panel members:
 • Haavi Morreim - why develop "relationships" with MCOs? (confirmed)
 • Mike Weber - health plan perspective (confirmed)
 • Ted Sadler, MD - should CMS be involved in monitoring plans? (confirmed)
 • Gene Sherman, MD - current CMS activities in managed care arena (invited)

11:30 am- Noon **"Where Do We Go From Here?" - Dr. Shanks**

Noon **Adjourn**

Keynote Speaker



E. Haavi Morreim, PhD,

E. Haavi Morreim, PhD, professor in the Department of Human Values and Ethics, College of Medicine, University of Tennessee, will keynote the President Elect's Planning Conference on May 2 and 3 at Sonnenalp in Vail. Prior to accepting her position in 1984, she was at the University of Virginia School of Medicine. She was named a full professor at the University of Tennessee in 1993. Dr. Morreim is the author of numerous articles and book chapters as well as *Balancing Act: The New Medical Ethics of Medicine's New Economics* published in 1991, republished in paperback in 1995.

Dr. Morreim received her PhD in philosophy in 1980 from the University of Virginia. She is a member of the American Society for Bioethics and Humanities, the American Society of Law, Medicine & Ethics, the Hastings Center and the National Health Lawyers Association.

Dr. Morreim will be recognized in the 53rd edition of Who's Who in America (1999), and in the 20th edition of Who's Who of American Women 1997-98, forthcoming. She is a member of Phi Beta Kappa.

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Copic Growing, Changing While Staying True to Colorado

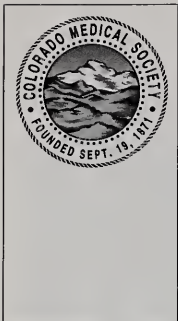
On March 4, 1998, Copic "broke out of the box," announcing a move that will permit us to serve policyholders beyond the borders of Colorado. On that date, we became a participant "partner" in *The Reciprocal Alliance Risk Retention Group (RRG)*. The partnership marks the beginning of a new era for Copic. In the next few weeks, you'll notice another significant change as we introduce Copic Companies, the "umbrella" corporate entity through which all of our business units will be marketed. These changes aren't merely cosmetic. They derive from our passion to anticipate and respond to new challenges, and they reflect our commitment to grow with you as your advocate and partner. Every endeavor that Copic undertakes proceeds directly from its mission, and these recent decisions are no exception. The mission of Copic Insurance Company is:

"...to provide for the needs of our customers, including a stable market for professional liability and other insurance products, principally in Colorado.

This will be accomplished through sound management, financial strength, optimum service, risk management, educational activities, strong leadership, and advocacy." Our participation in the Alliance is driven by the needs of our policyholders. Today, the rapid pace of integration has

created a need for physicians to "grow" their practices, position themselves to compete successfully for managed care contracts, and enhance cost-effectiveness. Many of you in group practice have entered into -- or are considering -- relationships with physician practice management companies (PPMs). Management alliances and PPMs often bring with them a comprehensive insurance program (medical liability, capitation stop-loss, etc.) from out-of-state sources. If Copic were to fail to respond to this situation, we would risk losing policyholders with multi-state affiliations, and the resulting loss of premium would have a detrimental effect on our ability to remain financially strong and provide market stability. First, a decrease in policyholders would mean a reduced ability to spread risk. Second, a reduction in premium volume would mean less premium available for the investments that fund policyholder distributions and policy enhancements such as long-term care, as well as Copic's operating costs. The need for Copic to serve policyholders beyond Colorado is not just theory... it's reality. This year alone, more than 1,200 Colorado physicians are potentially affected. There are at least seven physician practice management companies already operating in Colorado, and more than 125 nationwide. Copic's decision to join the Alliance provides us with the necessary means to

protect this part of our book of business. It also opens up an unprecedented opportunity for Copic to pursue markets for all lines of insurance, not just medical professional liability insurance. We have worked diligently over the last few years to create coverages, products, and services through Copic Insurance Company, Gadrian Corporation, Copic Financial Service Group, and Practice Quality to address almost every insurance or credentialing need a medical practice, hospital, or health plan could need. The creation of Copic Companies as an umbrella organization will help us to present ourselves both at home and in new markets as the "one-stop shop" we've become. Operating in concert, our combined corporate capabilities offer both depth and breadth for the myriad challenges facing modern health-care. We will invest much time and talent into taking best advantage of the identity and our new partnership ...but never at the expense of our commitment to you or to our core emphasis on medical professional liability insurance in Colorado. Our growth and success are attributable to you, and we greatly appreciate your continued trust and confidence in us. As your needs change, you can be assured that we will change to meet them.



Colorado Medical Society Hassle Factor Project Proposal

The goal of such a project would be to gather specific information regarding a wide variety of problems which physicians' offices are having with third party payers. As a result of information submitted to the CMS office, staff would assist the physician's office to resolve the problems.

The following steps would be taken:

- .. CMS staff would contact physician's office for details
- .. Initial complaint information would be added to a computer data base for tracking purposes
- .. CMS staff would contact the health plan to address the problem
- .. Possibly meet with the health plan if needed
- .. Complaint results would be added to the computer data base at CMS

The success of such a project will be dependent upon the willingness of the physician and his/her office staff to submit problem information to the CMS. If successful, this project would identify the source of various problems and allow Colorado Medical Society to take the appropriate action.

Some of the actions taken may include:

- .. Regular meeting with various health plans to discuss system problems identified, as well as possible streamlining of claims processing;
- .. Discussion with physician's office staff when claims filing errors or other office deficiencies are identified;
- .. Seek opinions from CMS Managed Care Task Force and/or the CMS/Colorado HMO Association Joint Committee, depending upon the issue;
- .. Seek the opinion of the CMS consultant, depending upon the issue;
- .. Development of a bimonthly newsletter for physicians' offices, summarizing problems and their status. This would also give information on how to avoid such problems in the future.
- .. Semi-annual meetings with physician office staff in each staffed component society;
- .. Meetings with the Colorado Division of Insurance when appropriate; and
- .. Annual quantitative analysis based on data received.

Practice office managers: Please complete the form on the following page and return it to CMS.

COLORADO MEDICAL SOCIETY

P.O. Box 17550, Denver, Co. 80217-0550

Phone: (303) 779-5455 or 1-800-654-5653 FAX; (303) 771-8657

HASSLE FACTOR MAILING LIST

In an effort to create a mailing list of all office managers for Colorado Medical Society (CMS) member physicians, we are asking you to fill out the following information. This information will allow CMS to send newsletters and communicate directly with the office manager for dissemination to appropriate office staff.

Please mail or fax this form to Edie Register at the address or fax number listed above.

Practice Name: _____ Specialty _____

Practice Address: _____

Practice Phone Number: _____ Fax Number _____

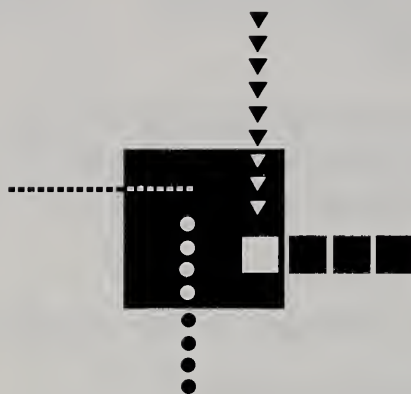
E-Mail Address: _____

Office Manager Name: _____

Office Manager Address: _____
(if different than practice)

Names of Physicians Within this Practice:

Your Success is Our Goal



American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

June 11-15, 1998
Sheraton Chicago Hotel and Towers
Chicago, Illinois

To succeed in today's health care environment, your medical staff needs the latest information and appropriate skills for meeting the day-to-day challenges of medical practice. By attending this meeting, you can learn about:

- Managing physician organizations
- Negotiating and resolving conflicts
- Helping and handling the disruptive physician
- Emerging information technology
- Capitation
- Stark II recommendations
- Antitrust
- Organized medical staff challenges in the future
- Effectively communicating in business practice
- PSOs and Medicare risk contracting
- Unionizing
- E/M Documentation Guidelines

In addition to these educational offerings, as an AMA-OMSS representative of your medical staff, you can participate in advocacy, policy-making and networking activities. **Our goal is to work with you to identify and address medicine's most pressing issues. We also want to help you increase your knowledge and skill so that together we can best serve the needs of patients, physicians, and the profession.**

To achieve this goal you can:

- ▼ Submit resolutions and participate in mode-of-practice and general interest forums to bring your concerns to the forefront.
- ▼ Testify at reference committee hearings and vote on actions in a democratic assembly to further AMA's advocacy agenda.
- ▼ Attend practical education programs to improve your medical practice, earn **8.5** hours of CME credit** and pay no fee to register!

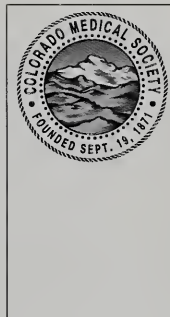
Your success depends on your involvement! Plan today to attend the 1998 Annual AMA-OMSS Assembly Meeting on June 11-15, at the Sheraton Chicago Hotel and Towers. To receive more information and registration materials, please call **800 621-8335** and ask for the **Department of Organized Medical Staff Services**.

* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

** The AMA designates this education activity for a maximum of 8.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

American Medical Association
Physicians dedicated to the health of America





The Pikes Peak Forum for Health Care Ethics

In recent years there has been a remarkable development of organizations throughout the United States whose interest is the study and application of medical ethics. The Pikes Peak region has its share of vigorous participation in this movement through several groups which include the ethics committee at each of our community and military hospitals, the broader based El Paso County Medical Society Medical Ethics Committee and the Pikes Peak Forum for Health Care Ethics.

The Pikes Peak Forum for Health Care Ethics is the newest of these philanthropic groups in our community and undoubtedly the widest scope of participants. It was formed in July 1996 in response to a perceived growing need for community-based guidelines to assist patients, their families, physicians, and other healthcare professionals in making reasonable and medically appropriate decisions in difficult situations. The formal organization of the Forum was preceded in our community by two "common ground" conferences convened in the fall of 1995 at the county court house and spring of 1996 at UCCS, both of which were inspired and initiated by District Court Magistrate E. David Griffith. Those conferences brought together a number of local health care professionals with representatives of the legal, religious and education professions to discuss such issues as "Community Values and Care of the Dying Patient."

Coincident with these conferences, the combined ethics committees of the El Paso County Medical Society and Bar Association developed and organized two conferences, which also involved concerned members of the lay community. These Community Coordinated Care Conferences laid the framework for the issues of the Forum. Representatives of the combined ethics committees facilitated the formation of the steering committee that organized the Forum.

Study Finds Physicians Doing a Good Job With Heart Drug

A study done by the Colorado Foundation for Medical Care (CFMC) has found that Colorado physicians are doing a good job of diagnosing and treating a common type of congestive heart failure.

Guidelines developed by the American College of Cardiology call for physicians to prescribe Angiotensin Converting Enzyme Inhibitors (ACE Inhibitors) when patients are found to be suffering from left ventricular systolic dysfunction (LVSD). The CFMC study found that among patients diagnosed with this type of congestive heart failure, 80 percent were prescribed ACE Inhibitors.

"We are very pleased this important cardiac medicine is being prescribed in 80 percent of the LVSD cases; just a few years ago, the same medicine was prescribed in only 50 percent of the LVSD cases," said

Edward P. Havranek, MD, a cardiologist from Denver Health Medical Center.

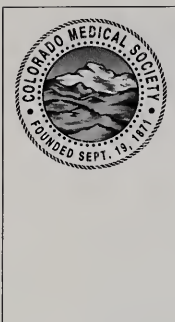
Havranek said the appropriate use of ACE Inhibitors has been shown to be effective in patients with congestive heart failure. The heart in a patient with congestive heart failure is not able to adequately fill or empty its left ventricle.

The condition is a serious one for the more than two million Americans who suffer from it. Some 400,000 patients are diagnosed with congestive heart failure each year, and studies have shown that, if not treated, 35 percent of these patients will die within one year of their diagnosis. Havranek said patients who are appropriately prescribed ACE Inhibitors have a significantly better survival rate.

For the study completed in 1997, registered nurses reviewed the medical records of 250 people with a diagnosis of congestive heart failure. The patients were treated at nine Colorado hospitals.

CFMC plans to repeat the study later this year to determine if its efforts to educate physicians on the appropriate use of ACE Inhibitors will result in an increase in the use of this drug.

CFMC, located in Aurora, is Colorado's federally-designated Medicare Peer Review Organization. The congestive heart failure study was paid for by the Health Care Financing Administration (HCFA) as a health care quality improvement project.



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ORTHOPEDIC MEDICALCONSULTANT needed in Denver area for Medical Case Management of Workers Compensation Claims. Must be Board Certified in Orthopedics with general medical knowledge. Part or Full Time work available with US Postal Service. Send CV and daytime phone number to David Bachman, MD, Senior Area Medical Officer, 1745 Stout St,#600, Denver, CO 80029. 03/0298

BEAUTIFUL ROCKY MOUNTAIN - busy established family practice affiliated with Boulder Community Hospital seeks a Board Certified Family Practitioner with an interest in complimentary medical approaches. Please send your resume to Boulder Community Hospital, Personnel, PO Box 9019, Boulder, CO 80301-9019. 06/0298

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DENVER - GROUP OF 4 NEEDS BC FAMILY PRACTICE MD for thriving practice near Porter. Call is 1 in 5, 130K & bonus. 2 to 10 yrs exp. Call 986-1909 or fax CV to 986-1509. This is an outstanding opportunity! 01/0498

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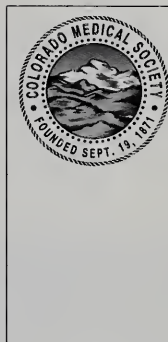
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AMERICAN CANCER SOCIETY SEEKING VOLUNTEERS to help with patient services & fundraising activities. ACS's Mile High Unit needs volunteers for: the Discovery Shop (upscale retail store), answering phones to connect patients with available medical resources, drive patients to and from treatments, and assist the office with accounting and data entry. The ACS is located at 2255 S. Oneida. For info/to volunteer, call 758-2030, ext 138. 01/0498

Attention Physicians! Did you know?

Tri-County Health Department, serving Adams, Arapahoe and Douglas Counties, provides free mammograms, breast exams, pelvic exams and Pap tests for qualifying, uninsured women ages 50-64. These services are made available through a cooperative program provided by the Colorado Women's Cancer Control Initiative, Tri-County Health Department, and the Susan G. Komen Breast Cancer Foundation.

You may request program materials for your office by calling Susan Moody, Cancer Screening Program Manager at 761-1340.



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*Don't let them Suffer
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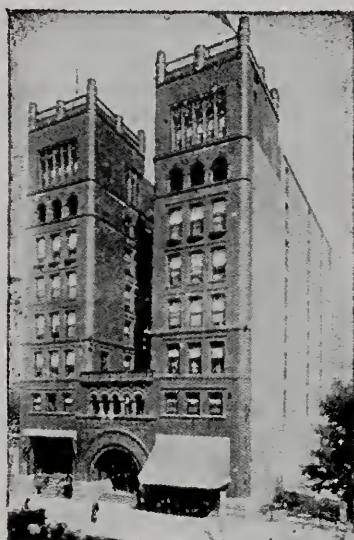
For additional resource materials, contact Chet Seward at the CMS offices: 779-5455 or 1-800-654-5653 or E-mail Chet_Seward@cms.org.



RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to REFLECT)

by **Bill Pierson**, Managing Editor



BROADWAY THEATRE AND METROPOLE HOTEL.

Did I talk about the *Broadway*? If I did, please forgive me for repeating myself, but short-term memory is one of the things that suffers in the aging process. HOWEVER, I do still have a lot of long-term memories, and it seems they're becoming sharper and brighter each day.

One of these is the old *Broadway Theatre*, located in the Metropole cum Cosmopolitan Hotel building at 18th and Broadway. All of it (except the memory) is gone now, but the *Broadway* was my first experience with the world of the grown-ups, and it was in the 1930s when **any** show of consumption impressed a child of my age and family resources. The *Broadway Theatre* was certainly a showy place.

As you entered through the center archway (seen in the picture in the center-front), the box office sat right in the middle of a long, tiled arcade-like foyer, which opened up onto several alternative auditorium entrances. These included the "stairway to heaven" or the "peanut gallery."

This gallery of less expensive seats seemed to me to be an almost-vertical tier of rows. I remember to this day sitting there in the front row and looking down on the stage. It was as if I were situated in the curtain loft and watching the activity directly below me. Participants on stage seemed so far away. The gallery must have been at the least the fourth storey of the building (which was eight storeys).

There was a highlight to my tale. It occurred when I won the privilege of sitting in a gilded box to the right of the stage proscenium. Here I was less than 15 feet off the stage floor. What a revelation! It was in that performance of some "internationally-known" magician when I also won the live rabbit that he pulled from his silk top hat. What a day! However, there was an unfortunate footnote to this rash of unbelievable luck: Not many days after I got the rabbit home, he escaped from his back yard cage and made it under the fence into the neighbor's flower garden., laying waste to many a prize bloom. The rabbit was dispatched.

I was amused by a recent newspaper story about the restoration of a building at 16th and Curtis Streets in Denver. The story said that a restaurant located in the newly-

refurbished structure was to be named the "Rialto Cafe," but the restaurateur did not know that in a building next door was the grand old *Rialto Theatre* (demolished many years ago). The builders probably also didn't know that right across the street was the truly world-famous *Tabor Opera House*, much of the same era as the *Broadway Theatre*. And across 16th Street was the *American Theatre* next to the *Victory* (circa WWI) and on down, the *Isis*.

Curtis Street was "Theatre Row", the "Street of Lights", a magical place of legitimate theatre as well as vaudeville and film. It was a fascinating place with an "other world" eminence to me. Tucked in between theatres was "*Sam's Coney Island*", a cafe of questionable repute but always a fascinating scene to me. Through the front window you looked across the grill at the end of the counter, and you always knew that there was more to this place than the 12-stool counter and grill, but it took nerve to go into this denizen of New York's Broadway-type characters. In later years when I officed nearby, I went there regularly and found "*Sam's*" to be the central gathering place of Denver's Greek adult male population, complete with a large, smoke-filled card room at the back (legit). Nearby was the "*Economy Grocery*" where I bought imported *feta* cheese still curing in the kegs of brine.

The "Rialto's" of today should look around more; they'll find many a hidden story of a colorful and lively Denver, a "**Great City**" generations before our "baby-boomer" Mayor came up with his slogan.



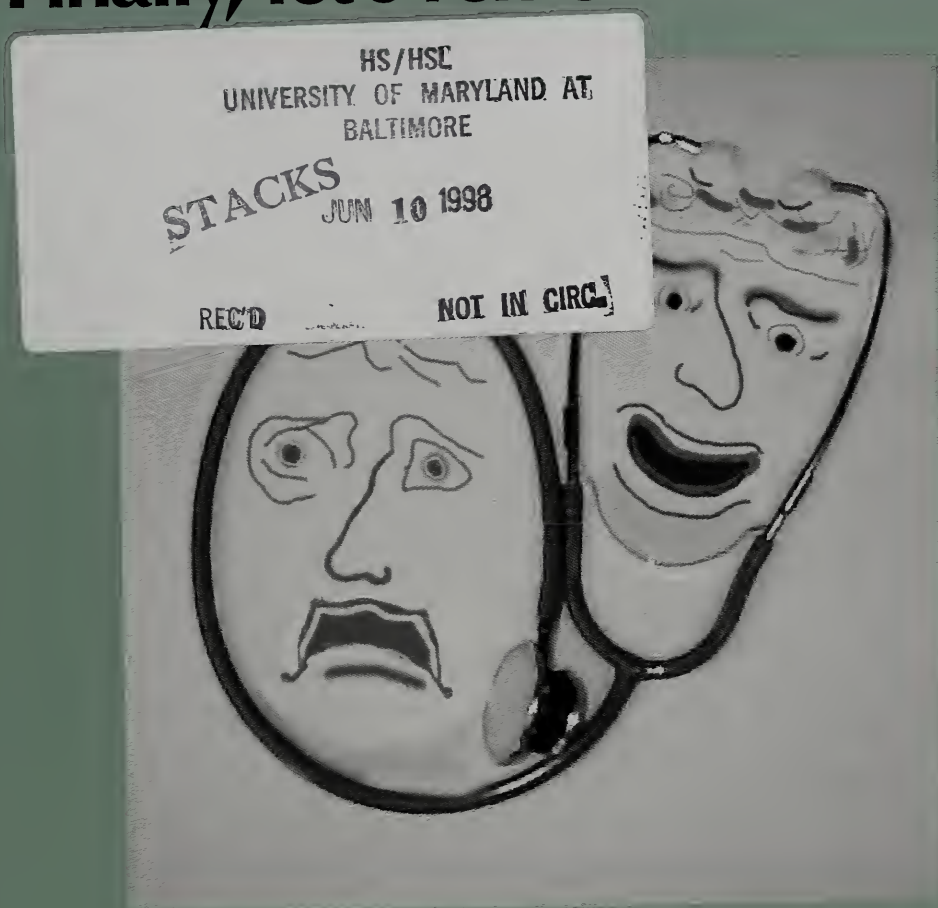
COLORADO MEDICINE

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1998

Volume 94, Number 5

Finally, let's remove the masks!



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Mental Health and Suicide: U. S. Surgeon General says "let's talk about it!" May is National Mental Health Month

See page 158

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- May - Mental Health Month** Time to talk about cause and effect **page 158**
- Accountability** by Donald G. Eckhoff, MD, MS, FAGS **page 160**
- Archives: Hospitals of the Rural West** by John L. Lightburn, MD **page 165**



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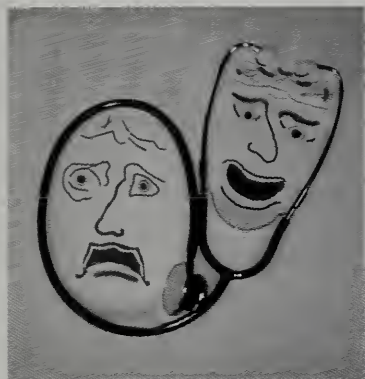
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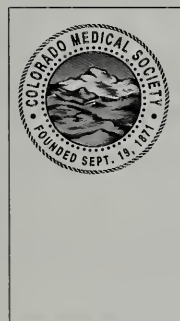
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Cover Story

The U.S. Surgeon General has announced that suicide will become a major priority for his offices, noting that suicide has not been debated or talked about enough.

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor.
<http://www.cms.org/ColoradoMedicine.html>



Member, Colorado Press Association,



Member, Colorado Broadcasters Association



Colorado Medical Society Hassle Factor Project Proposal

The goal of the project is to gather specific information regarding a wide variety of problems which physicians' offices are having with third party payers. As a result of information submitted to the CMS office, staff would assist the physician's office to resolve the problems.

The following steps would be taken:

- .. CMS staff would contact physician's office for details
- .. Initial complaint information would be added to a computer data base for tracking purposes
- .. CMS staff would contact the health plan to address the problem
- .. Possibly meet with the health plan if needed
- .. Complaint results would be added to the computer data base at CMS

The success of such a project will be dependent upon the willingness of the physician and his/her office staff to submit problem information to the CMS. This project can identify the source of various problems and will allow Colorado Medical Society to take the appropriate action.

Some of the actions taken may include:

- .. Regular meeting with various health plans to discuss system problems identified, as well as possible streamlining of claims processing;
- .. Discussion with physician's office staff when claims filing errors or other office deficiencies are identified;
- .. Seek opinions from CMS Managed Care Task Force and/or the CMS/Colorado HMO Association Joint Committee, depending upon the issue;
- .. Seek the opinion of the CMS consultant, depending upon the issue;
- .. Development of a bimonthly newsletter for physicians' offices, summarizing problems and their status. This would also give information on how to avoid such problems in the future.
- .. Semi-annual meetings with physician office staff in each staffed component society;
- .. Meetings with the Colorado Division of Insurance when appropriate; and
- .. Annual quantitative analysis based on data received.

Practice office managers: Please complete the form on the following page and return it to CMS.

COLORADO MEDICAL SOCIETY
P.O. Box 17550, Denver, Co. 80217-0550
Phone: (303) 779-5455 or 1-800-654-5653 FAX; (303) 771-8657
HASSLE FACTOR MAILING LIST

In an effort to create a mailing list of all office managers for Colorado Medical Society (CMS) member physicians, we are asking you to fill out the following information. This information will allow CMS to send newsletters and communicate directly with the office manager for dissemination to appropriate office staff.

Please mail or fax this form to Edie Register at the address or fax number listed above.

Practice Name: _____ Specialty _____

Practice Address: _____

Practice Phone Number: _____ Fax Number _____

E-Mail Address: _____

Office Manager Name: _____

Office Manager Address: _____
(if different than practice) _____

Names of Physicians Within this Practice:

_____	_____
_____	_____
_____	_____
_____	_____
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...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax[®]

by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

HCFA Delays E & M Documentation Guidelines Again

It was announced at the AMA "fly-in" on Monday, April 27, 1998, that HCFA has postponed the implementation date for the revised E & M documentation guidelines, again. The HCFA Administrator, Nancy Ann Min DeParle told the AMA in a letter that they will not set a new implementation date until this fall, after the guidelines are revised and a plan for testing, refinement and physician education has been worked out. In the meanwhile, HCFA is directing the Medicare Carriers to continue to use both the 1995 and 1997 guidelines, whichever is more advantageous to the physician.

There will be significant changes to the examination guidelines. Indications are that the bullet system will remain. That is, bullets will still be used to identify the elements of an exam, however, the various specialty exams will be collapsed into one with a long list of elements from which to choose. It is anticipated that the effective date will be sometime in 1999, probably 7/1/99.

As more information is received we will let members know. If you have any questions, you can contact Marilyn Rissmiller in the CMS Health Care Financing Department at 779-5455 or 1-800-654-5653, ext. 2428.

ACP Board of Regents

Three new regents and four incumbents have been elected to three-year terms on the American College of Physicians Board of Regents. Their terms began during ACP's 79th Annual Session, in San Diego. The 30-member board of Regents manages the business and affairs of ACP. One of the Regents elected for a first term was, **Robert B. Gibbons, MD**, of Denver, an internist and rheumatologist who is program director of internal medicine residency, vice chairman of the department of medicine at Saint Joseph Hospital and clinical professor of medicine at the University of Colorado School of Medicine.

CALL FOR NOMINATIONS

The Colorado Medical Society will be holding elections at the upcoming Annual Meeting in September. CMS requests nominations for the following:

- American Medical Association (AMA) Delegates
- AMA Alternate Delegate
- Vice-Speaker of the House of Delegates
- President-elect

Dr. Richert Quinn is running for re-election as AMA Delegate.

Dr. Robert McCartney is running for re-election as AMA Alternate Delegate.

Dr. Sherri Laubach is running for re-election as Vice-Speaker of the CMS House of Delegates.

If you are interested in running for any of the above offices, please submit your name and a current resumé to the CMS Executive Office, PO Box 17550, Denver, CO 80217-0550. If you have any questions, please contact either Sandra Maloney or Debra Jones at 303-779-5455 or 1-800-654-5653.

Immunizations Most Effective Disease Prevention Known

Childhood immunizations are among the most medically effective and cost-effective methods of preventing serious diseases, yet more than one million American preschoolers are still not adequately immunized. Rocky Mountain HMO is working to change that statistic through programs designed to assist parents.

In addition to covering childhood immunizations at no cost under most benefit packages, Rocky Mountain HMO sends parents notices when their infants are due for recommended shots.

Young Rocky Mountain HMO members who receive all recommended shots by their second birthday are also eligible to receive teddy bear T-shirt proclaiming "I got my shots by 2!"

Rocky Mountain HMO members who become new parents also receive a "new baby" packet that includes information on the importance of having their child immunized, a recommended immunization schedule, and a vaccine record for keeping track of baby's shots.

Each child's physician can determine the best immunization schedule for them, but general guidelines for immunizations against hepatitis B, diphtheria, tetanus, pertussis, H.influenza type b, polio, measles, mumps, rubella and varicella have been endorsed by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians.

Generally, the full series of vaccination can be given in five visits to a doctor or clinic between birth and 18 months.

Before widespread immunization in the United States, infectious diseases killed or disabled thousands of children each year. Tens of thousands of cases of paralytic polio and more than 500,000 measles cases were reported annually. Development of vaccines reduced the occurrence of such childhood diseases by more than 99 percent.

The national infant immunization rate is now at an historic high of 76 percent, and most vaccine preventable childhood diseases are at all-time lows. This successful reduction in the incidence of infectious

diseases has unfortunately resulted in many Americans thinking immunizations are no longer necessary.

The Centers for Disease Control (CDC) warns, childhood illnesses that can be prevented by immunization are still with us and still claim the lives of children in the U.S. every year. Approximately 3.5 million cases of chickenpox are estimated to occur each year. In 1989 to 1991, a measles epidemic resulted in more than 55,000 reported cases, 11,000 hospitalizations and about 120 deaths. And more than one million American preschoolers are still not adequately immunized against vaccine-preventable diseases.

According to the CDC, "The viruses and bacteria that cause these diseases and death still exist. They have not disappeared. Use of vaccines has dramatically reduced the number of people who get infectious diseases and the complications these diseases produce. Without the protection of vaccines, epidemics of vaccine-preventable disease would return, resulting in increased illness, disability, and death."

"While the World Health Organization declared the Western Hemisphere free of polio in 1994, these extraordinary results can only be maintained if children continue to be immunized," stresses David Herr, MD, pediatrician and associate medical director for Rocky Mountain HMO.

"Our system of low or no copayments for immunization removed the financial barrier to get kids immunized," said Dr. Herr. "Our reminder system makes it difficult for parents to forget this vitally important preventive care step."

Rocky Mountain HMO encourages parents to contact their doctor to review their child's immunization records and to get the necessary shots if they are not up to date.

"Getting immunized is one of the easiest things you can do to protect your child from very serious illness," said Dr. Herr.

For more information about the health plans' T-shirt reward program, Rocky Mountain HMO members should call 1-800-346-4643.

Health, Environmental Leaders Institute Enrolling First Class

An institute designed to develop new, innovative leadership for the public and private health care and environmental health communities in Colorado and Wyoming now is enrolling its first, 35-member class.

The new Regional Institute for Health and Environmental Leadership, one of only 13 such regional institutes in the country, is the outgrowth of a yearlong planning effort involving the Colorado Department of Public Health and Environment; the University of Colorado Health Sciences Center; the University of Denver; and the University of Northern Colorado.

Lee Thielen, the associate director of Colorado's health department who first identified the need for such a leadership institute and launched the planning work, said, "The health and environment professions are changing rapidly. A critical need exists for strong leadership that recognizes the important role of a broad health system and the interplay of the public and private sectors needed to solve community problems. We believe this institute will help develop the kind of leadership needed to move us successfully into this new era."

William Shatz, director of DU's Institute for Health Systems Leadership and Research, who was instrumental in bringing the university consortium together, said, "Historically, our health system has been characterized by fragmented structures, incentives and effort. This institute envisions the training and development of health system professionals who will lead their institutions toward a progressive model of health improvement which transcends organizational and geographical boundaries and reflects the rapid convergence among stakeholders in our health system."

Also actively involved in developing the consortium were Dr. Tim Byers, a professor of preventive medicine at the CU Health Sciences Center; Dr. William Ebomoyi, a UNC associate professor community health and nutrition; Dr. Carl E. Larson, a DU professor of human communications studies and the university's former dean of social sciences; Dr. Bernard W. Nelson,

professor of preventive medicine and former chancellor at the CU Health Sciences Center; Dr. William G. Parkos, a UNC professor of community health and nutrition; and Dr. William S. Silver, director of educational technology for DU's Daniels College of Business.

Byers, Larson and Silver will serve as the permanent faculty for the institute with their work to be augmented by visiting faculty members.

The Lutheran Medical Center Foundation; the Colorado Department of Public Health and Environment; the Centers for Disease Control in Atlanta; and the Region 8 office of the U.S. Public Health Service are providing funding for the institute.

The yearlong leadership training, which will begin in July, will center around four three-day seminars. The seminars will be augmented by course work conducted over the Internet and by team projects. Study topics will range from evolutionary leadership to community health assessment and collaborative problem solving.

Those being encouraged to apply for institute participation are mid-level and senior-level executives from managed care organizations; private medical practices; hospitals; state and local public health and environmental health agencies; private industry, with a particular emphasis on those involved in environmental health issues; and charitable organizations. Three of the 35 slots are reserved for Wyoming residents. The remainder will come from Colorado.

Applications for admission to the institute, which must be submitted by May 25, should be sent to the Regional Institute for Health and Environmental Leadership at the University of Denver where it will be based. The address is 2211 South Josephine Street, Denver, CO 80208. Kathy Kennedy, the institute director, can be reached at (303) 871-2097 or through her email at kkennedy@du.edu.

Tuition for the program is \$2,100, less a scholarship of \$500 for Colorado residents. The scholarship assistance is being provided through the Lutheran Medical Center Foundation grant to the institute.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Arapahoe Medical Society Annual Meeting

Thursday, May 14, 1998

Willshire Inn

Reservation must be made by May 11.

(303) 761-2887 or email: ams@ecentral.com

Health Care Benchmarking: from Data to Decisions

May 18, 1998

Radisson Hotel Denver South

Englewood, CO

Contact: Peggy McCreary at CHA

(303) 758-1630

Root Cause analysis for Health Care Professionals

June 15, 1998

Cherry Creek Inn

Denver, CO

Contact: Peggy McCreary at CHA

(303) 758-1630

JCAHO: Accreditation Standards and Survey Process for Laboratories

June 12, 1998

Denver Marriott Southeast

Denver, CO

Contact: Peggy McCreary at CHA

(303) 758-1630

Colorado Otolaryngology and Maxillofacial Society Rocky Mountain Ear Round-up

July 23 - 24, 1998

Brown Palace Hotel

321 Seventeenth Street

Denver, CO 80202

Contact: Bob Conlon, MD or Debbie Brown,

(970) 484-8686

The Managed Care Shakeout

Implications for Consumers and Providers

18th Annual Dorsey Hughes Symposium

July 23 - 25, 1998

The Vail Cascade Hotel & Club

Contact: Khanh Ngyen at HealthONE

(303) 322-3515 or email - ktnguyen@ecentral.com

12th Annual Echocardiographic Symposium on 2-D and Doppler Echocardiography - sponsored by American College of Cardiology

August 2-6, 1998

Marriot's Vail Mountain Resort

Vail, CO

Contact Registration Secretary, Extramural Programs

1-800-253-4636 ext. 695

15th Annual Santa Fe Colloquium on Cardiovascular Therapy - sponsored by American College of Cardiology

October 8 - 10, 1998

Eldorado Hotel

Santa Fe, New Mexico

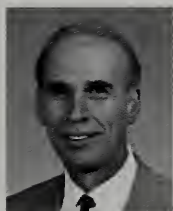
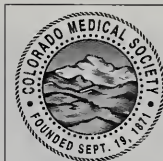
Contact Registration Secretary, Extramural Programs

800-253-4636 ext. 695

Watch for **The 120 DAY Newsletter**, a publication distributed once a year by the **Colorado Medical Society**, a complete legislative summary at the close of the first session of the 62nd General Assembly.

Send us your calender items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.



Gary D. VanderArk, MD
President, 1997-1998

The love of my life came home from a trip to Alfalfa's the other night with a bottle of ginkgo biloba. When I saw it, I had two questions. What's this for and how much did it cost? My wife replied that all of her friends were taking it to improve their memories and therefore, the second question was irrelevant. After all, how much is improved memory worth?

Before I became too critical, I thought back over my own actions in the past year. Hadn't I tried taking chondroitin sulfate and glucosamine myself in an attempt to alleviate my arthritic aches and pains? Hadn't I resorted to manipulation for my acute low back strain when I awoke completely incapacitated on a day when I had two major surgical cases scheduled?

So I guess the VanderArks aren't much different than the rest of Americans. It's estimated that between one-third and one-half of citizens of the United States have seen an alternative medicine provider in the past year. Joe Bujak at the annual meeting said that Americans spend one-half as much out-of-pocket dollars for alternative medicine as for conventional care.

But what is Alternative Medicine? We seem to have trouble even agreeing on a definition. Does alternative mean not what I've been taught? Or does alternative mean complementary or unconventional? Many state legislatures have attempted to define it as only lawyers could. Oregon, for example says, "Alternative treatment means:

- 1) A treatment that the treating physician, based on the

physician's professional experience, has an objective basis to believe has a reasonable probability for effectiveness in its intended use even if the treatment is outside recognized scientific guidelines, is unproven, is no longer used as a generally recognized or standard treatment or lacks the approval of the FDA;

- 2) A treatment that is supported for specific usage's or outcomes by at least one other physician licensed by the Board of Medical Examiners; and
- 3) A treatment that poses no greater risk to a patient than the generally recognized or standard treatment."

Those within our ranks who use manipulation or acupuncture may not even see themselves as alternative medical providers. After all, homeopathic remedies have had legal status since 1938 and Homeopathic Pharmacopoeia of the United States is still recognized by the FDA. Hasn't the Agency for Health Care Policy and Research (AHCPR) recognized manipulations one of the few proven remedies for acute low back pain? Aren't the managed care companies in Colorado jumping on the bandwagon and providing coverage for Alternative Medicine? The federal government through The National Institutes of Health (NIH) has established the Office of Alternative Medicine and their budget for 1998 is 40 million dollars to provide a clearing house for information on alternative medicine.

Your medical society has not remained inactive on these issues. President Ray Painter in 1996 appointed an Alternative Medicine

Alternative Medicine - Our Opportunity

Task Force. This group under the chairmanship of Bart Goldman has a goal to define Alternative Medicine and to determine criteria for determining acceptable treatments. They have surveyed our membership. To no one's surprise, many of you are using Alternative Medicine in your practices. I was personally delighted to see prayer at the top of the list of frequently used modalities.

Now comes the dictum in the form of passed Resolution 1P from the 1998 Interim Meeting of our House of Delegates:

"RESOLVED, physicians should be encouraged to inquire about the use of alternative or unconventional therapies by their patients; and be it further RESOLVED, that the CMS encourages scientific research to evaluate the efficacy of alternative therapies".

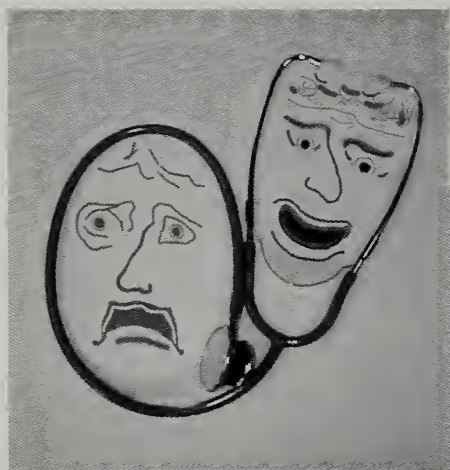
Then the Reference Committee recommended that the Program Committee consider developing an educational program on Alternative Medicine to be conducted at a future annual meeting. So the CMS has its marching orders.

Well, didn't I say we were going to lead the way to accountability? Doesn't this provide us with a wonderful opportunity? I think our Accountability Committee has a new challenge.



ental health/suicide: let's talk about it

What do they use to mask their feelings?



Mental illness: something that few of us like to think about, because the subject has so many ramifications, all of which are unpleasant to contemplate.

May is National Mental Health Month to the greater understanding of the subject and to help us all to a healthier mental state.

There are staggering statistics just recently published by one of the pharmaceutical manufacturers regarding mental illness in the United States. Outstanding among the statistics is an illness which most every human experiences at least once in their lives: **depression**. This form of mental illness isn't even recognized by the majority of people afflicted. Why? Because it is a natural phenomenon affecting all humans at some time in their lives, to one degree or another. But there are hundreds of thousands of U. S. citizens who suffer endlessly with "clinical depression." More common than this is what is now called "bipolar disorder," formerly referred to as "manic depressive illness."

Among physicians this is common knowledge, but during the month of May a greater awareness should be promoted about this malady.

Approximately 1% of the world's population is thought to have some form of bipolar disorder, from mild to severe, and one in five people with bipolar disorder commit suicide (Goodwin and Jamison, *Manic Depressive Illness*, pp. 227-228). Prompted by the fact that this rate is 30 times higher than the general population, and coupled with the sharp increase in the number of youth suicides, the **U. S. Surgeon General, Dr. David Satcher**, has announced that suicide will become a major priority for his offices. Dr. Satcher notes that suicide has not been debated or talked about enough and that open and frank discussion and recognition of the mental illness which leads to these

deaths is of the utmost importance to citizens of the world.

Here are some of the disturbing statistics (supplied by the American Foundation for Suicide Prevention) with which we can start the discussion:

1. Each year, 51 million Americans suffer from mental and emotional disorders ranging from phobia to psychosis.
2. Ten percent of American adults, more than 17 million people, suffer from major depressive illness every year.
3. 90% of adolescent suicide victims have at least one diagnosable, active psychiatric illness at the time of death -- most often depression, substance abuse, and conduct disorders. Only 33-50% of suicide victims were identified by doctors as having a mental illness at the time of their death, and only 15% were in treatment at the time of death.
4. Suicide is the 2nd leading cause of death among college students.
5. Suicide is the 3rd leading cause of death among all those 15-24 years old.
6. The suicide rate for all children (10-14) has more than doubled over the last 15 years.
7. Alcoholism is a factor in about 30% of all completed suicides.
8. 96% of alcoholics who commit suicide continue their substance abuse up to the end of their lives.
9. The American Foundation for Suicide Prevention reports that the highest suicide rate occurs in those over 50. In more than half of those deaths medical illness plays an important role in the motivation to commit suicide.

Mental Health/Suicide

(Continued from preceding page)

10. The suicide rate for young black males (15-24) has risen by 2/3 in only the past 15 years.
11. Two thirds of those with any kind of affective disorder who do receive treatment will be misdiagnosed. According to the World Health Organization, nearly 70% of patients with mental health problems present physical symptoms such as sleeplessness, vague aches and pains, and fatigue*.

One of the most disturbing traits of today's young people (particularly age 15 to 24) is the consumption of alcoholic beverages leading to substance abuse and alcoholism. Also disturbing is that clinicians know that depression drives an increased consumption of alcohol and use of drugs and halucogenic substances. It is difficult or impossible to determine how much of this substance abuse is caused by or fueled by depression. It is known that a large percentage of substance abusers suffer some form of mental illness. The combination of these elements can be seen to be a major cause of suicide among the young.

In summary, what was thought to be a social disorder is now seen as the result of a majority of cases of depression, leading to substance abuse and (again, in a majority of cases) suicide or attempted suicide.

The *Global Burden of Disease*,** a landmark project orchestrated by the World Health Organization, the Harvard School of Public Health and the World Bank, estimates that by the year 2020 depression will be the second most burdensome illness in the world.

* The Facts About Clinical Depression, Organon, Inc.

** National Institute of Mental Health, Bethesda, MD

Colorado	Physician	Network, Inc.					

by David M. Martz, MD
President CPN



RMHMO and Denver-Metro Medicaid

Many of you may have heard about changing relationships between RMHMO and Medicaid in the Denver-Metro area through the public media, direct personal communication from RMHMO, or physician lounge conversation. As this constitutes a major change in our policy--hopefully on a temporary basis--it seems appropriate to address it clearly in this column.

Over the past 2 years, RMHMO has sustained massive financial losses in the Denver-Metro Medicaid sector: in 1997 alone these amounted to \$2.7 million. These are attributed to the combination of adverse patient designation to RMHMO (particularly in areas where other managed care organizations do not offer physician panels comparable to RMHMO), and failure of the state to keep pace with appropriate reimbursement levels of this population. Both of these issues have been thoroughly presented to the state, and there is some hope of modification in the months ahead. Meantime, however, measures must be taken to stem the hemorrhaging.

As of April 1, 1998, RMHMO Medicaid patients in Arapahoe, Adams, and Jefferson counties (except

those in the Provenent network) must transfer their care to:

1. The state Primary Care Physician Program (PCPP); or,
2. The state Medicaid fee-for-service program; or,
3. Another managed care program that provides Medicaid HealthCare services.

RMHMO has already notified the affected physicians in writing of these changes, including a contract modification agreement.

No RMPC physician will lose RMHMO commercial or Medicare patients as a result of this action. Furthermore, the approximately 200 Primary Care Physicians in Arapahoe, Adams, and Jefferson counties whose RMHMO Medicaid patients are affected may maintain continuity of care (if desired) by encouraging their Medicaid patients to choose one of the three options listed above in which the physician participates.

We congratulate the Provenent program for their effective Medicaid management, and look forward to the day when appropriate corrective measures will allow a return of RMHMO Medicaid participation in all areas.

If you have any questions, you may contact Greg Coren, RMHMO Manager of Provider Relations, at (970)244-7924.



ACCOUNTABILITY



by Donald G. Eckhoff, MD, MS, FAGS
University of Colorado Health Sciences Center

At the individual practice level, practice specific data from "pathways" or "care plans" can be collected and analyzed to document the effectiveness of patient care.

There is a growing need for all physicians to address the concerns and challenges which are now a part of our professional lives. The individual and collective response to these concerns and challenges is the "new professionalism" described by Dr. John Wenneberg. This new professionalism is reflected in individual and collective efforts to establish accountability and improve the health care of entire populations. This new professionalism obligates physicians to active participation in outcomes research at the level of the community based practice. The community based physician must play an active, if not pivotal, role in this process of accountability.

Traditionally, however, research is the preview of the academic physician and the academic medical center. Research has typically flowed from the academic center to the community practice, from the academician to the community physician. The role of the community physician has been to implement, not innovate. This old research paradigm must change. The problem is there are few models to guide the community based physician in this activity.

The purpose of this presentation (and that of the 1997 CMS leadership seminar of which it was a part) is to demonstrate working models to guide community based physicians who wish to initiate outcomes research. The goal of this effort is to encourage community physicians to become the leaders, not followers, in accountability and outcomes research. With this goal in mind, the following two models currently

working in our community are presented as examples.

At the individual practice level, practice specific data from "pathways" or "care plans" can be collected and analyzed to document the effectiveness of patient care. These pathways or care plans which standardize the care of a group of patients with a specific diagnosis can be monitored and variation in outcomes documented. Pathways and care plans have four essential ingredients which are 1) a physician champion, 2) a group process that includes all caregivers involved with patient care on the pathway, 3) hospital cooperation, and 4) measurable outcomes. Pathways and care plans typically increase quality of care and patient satisfaction at the same time that they improve cost effectiveness. They establish accountability and improve outcomes at the individual practice level.

Pathways and care plans are easily within the scope of every community based practice. An illustration of this mode from a local practice is found in a pathway for total joint replacement that demonstrated patients donating autologous blood frequently required post-operative transfusion while those not donating did not need transfusion. This information helped the operating team recognize that the need for post-operative transfusion was often the result of an iatrogenic anemia created by the act of autologous donation. This recognition led to a modification in the care plan that decreased both the donation of and transfu-

sion of autologous blood, improving both the quality and cost of care.

At a community, regional or national level, practice data from pathways and care plans can be pooled to create population based effectiveness of treatment in the hands of multiple community physicians. The model for pooled data is the "registry" to which community physicians contribute their individual practice data and reap the benefits of a much larger and more powerful data base. Data from such a registry often demonstrates practice pattern variation which, when returned to the individual physicians in a confidential and non-threatening way, can have a significant impact on modifying practice patterns behavior.

As an example of a "registry", a locally constructed data base of patients with stroke or hip fracture demonstrated that rehabilitation units were effective in the treatment of stroke but not in the treatment of hip fracture. Cost was found to vary significantly by geographic region. Outcome was ultimately dependent

on premorbid diagnosis and the presence of social support.

While this particular stroke and hip fracture data base is supported by a large federal grant administered by the University Health Policy Center, similar registries have been developed by the Data Committee of the Colorado Medical Society and the Colorado Hospital Association to pool data and profile Colorado practice patterns. Unfortunately, these latter efforts have to large extent been rendered ineffective when the process became politicized. This point illustrates the need to keep outcomes research out of the political arena and the popular press. Never the less, CMS and other organized physician groups need to continue to assist community based physicians in their efforts to pool data. In an era when the role of groups like CMS in the life of physicians in diverse practice settings is becoming increasingly difficult to define, establishing registries and disseminating the data back to member physicians may become a core function.

In his article entitled "Assessment and Accountability, the Third Revolution in Medical Care", Arnold Relman characterized the decades from 1940 to 1960 as the expansion era, decades from 1960 to 1990 as the cost containment era, and the decade of the 1990's as the era of assessment (outcomes research) and accountability. Outcomes research throughout the 1990's has identified the problems of practice pattern variation, rapid increase in cost of care deficiencies in the scientific basis of medical practice, and demonstrated the excess supply of specialty trained physicians. As we move toward the end of this decade, it is clear that assessment and accountability have only just begun. Individually and collectively, physicians will need to become increasingly active in assessment and accountability. Regardless of the changes that continue to reshape the health care delivery system, preservation and improvement in the quality of health care will be the ultimate goal of physicians who accept their role in the new professionalism.

Call for Nominations

Colorado Medical Society Certificate of Service

Each year, Colorado Medical Society awards a physician with the prestigious Colorado Medical Society Certificate of Service, recognizing outstanding effort and devotion to the purposes of organized medicine. The award is given to an individual who displayed unusual efforts on behalf of the Colorado Medical Society, or noteworthy contributions to the practice of medicine in Colorado.


This award, given by the Colorado Medical Society House of Delegates at each year's Annual Meeting, goes to a physician named by his/her peers. You are urged to consider this award and the activities at both state and local levels, and nominate that individual whom you feel has made an outstanding contribution.

Nominations are due on or before June 30, 1998.

Please call CMS at 1-800-654-5653 or (303) 779-5455, extension 2418, to request a nomination form.

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Orders must be received by April 30, 1998 to be printed in second quarter

Order today and let your patients know that you are a proud member of the Colorado Medical Society

The Colorado Physician Health Program Twelfth Annual Meeting and Physician Health Forum

Thursday, May 21, 1998
Denver Marriott Southeast

PROGRAM

2:30 - 3:00 P.M. Registration (preregistration required - see form below)

3:00 - 5:30 P.M. Welcome and Introductions

Physician Health Forum

*Boundaries of the Physician-Patient Relationship:
Old Traditions, New Frontiers or Simply Politically Correct*

Keynote: David S. Wahl, MD

Case Study: Michael H. Gendel, MD
A survey of Physician Prescribing of Medical Treatment to
Themselves and Their Family

Panel Discussion: Doris C. Gundersen, MD
Psychiatrist

Matthew E. Norwood, Esq
First Assistant Attorney General, Regulatory Law Section

George O. Thomasson, MD
Vice President, Risk Management - Copic Insurance Company

Andrew Wiesenthal, MD
Associate Med. Director, Colorado Permanente Medical Group

5:30 - 6:30 P.M. Reception (hors d'oeuvres and desserts)

REGISTRATION

NAME _____ *First name* _____
for name tag

ADDRESS _____

ORGANIZATION _____

TITLE OR POSITION _____

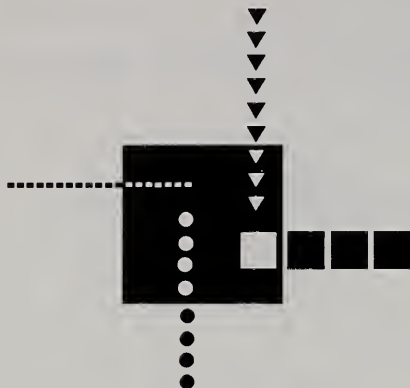
DAYTIME PHONE _____

FEE ENCLOSED _____

if received **before** May 15, 1998 \$25, if received **after** May 15, 1998 \$30

**Make checks payable and mail to: CPHP - Twelfth Annual Meeting,
899 Logan Street, Suite 410, Denver, CO 80203**

Your Success is Our Goal



American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

June 11-15, 1998
Sheraton Chicago Hotel and Towers
Chicago, Illinois

To succeed in today's health care environment, your medical staff needs the latest information and appropriate skills for meeting the day-to-day challenges of medical practice. By attending this meeting, you can learn about:

- Managing physician organizations
- Negotiating and resolving conflicts
- Helping and handling the disruptive physician
- Emerging information technology
- Capitation
- Stark II recommendations
- Antitrust
- Organized medical staff challenges in the future
- Effectively communicating in business practice
- PSOs and Medicare risk contracting
- Unionizing
- E/M Documentation Guidelines

In addition to these educational offerings, as an AMA-OMSS representative of your medical staff, you can participate in advocacy, policy-making and networking activities. **Our goal is to work with you to identify and address medicine's most pressing issues. We also want to help you increase your knowledge and skill so that together we can best serve the needs of patients, physicians, and the profession.**

To achieve this goal you can:

- ▼ Submit resolutions and participate in mode-of-practice and general interest forums to bring your concerns to the forefront.
- ▼ Testify at reference committee hearings and vote on actions in a democratic assembly to further AMA's advocacy agenda.
- ▼ Attend practical education programs to improve your medical practice, earn **8.5** hours of CME credit** and pay no fee to register!

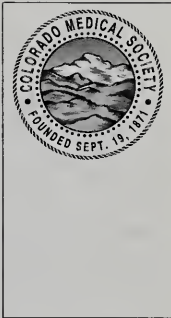
Your success depends on your involvement! Plan today to attend the 1998 Annual AMA-OMSS Assembly Meeting on June 11-15, at the Sheraton Chicago Hotel and Towers. To receive more information and registration materials, please call **800 621-8335** and ask for the **Department of Organized Medical Staff Services**.

* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

** The AMA designates this education activity for a maximum of 8.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

American Medical Association
Physicians dedicated to the health of America





by John L. Lightburn, MD
Historian, Colorado Medical Society

A Scenic Tour of Western Colorado Hospitals of the Rural West

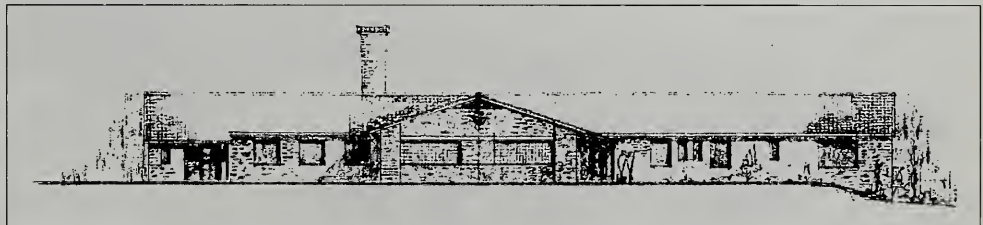
As our profession seeks to find solutions to the dilemmas presented by the current changes in health care financing, it may be useful to recall how our predecessors solved dilemmas confronting them. Just as we seek to retain our professional integrity in spite of forces that alienate us from our patients, so our colleagues from an earlier time worked on behalf of their patients in spite of diagnostic and therapeutic limitations imposed by a different reality that was perhaps more daunting than the reality we face. How did they cope?

For some answers, we continue with the history of rural Colorado health care to learn how physicians and communities sought to overcome the obstacles to health care in unique and creative ways. Building hospitals was one way they sought to deal with their health care problems. Of the 69 hospitals currently in the state, 39 are in smaller communities in rural Colorado, each with its own history. Traveling west on Interstate 70, we find several small communities with interesting medical histories. Glenwood Springs is a good example. Following World War II, Glenwood had three small private hospitals, two of which were about to go under. There was a hospital in the old red stone bath house next to the hot springs swimming pool. In the distant past, the native Americans had used the curative powers of those hot springs, but the springs provided no magic for this struggling little hospital. Uptown on the third floor of the First National Bank building, Dr. Burris Nutting was

somewhat more successful with his small hospital and medical office (not as impressive as the one at the hot springs but it served its purpose). He was doing OK, but he realized that the town was growing and his small operation could not continue to meet the needs of the community.

So Dr. Nutting joined together with some of the movers and shakers of the community to build a more

stepped off the Denver and Rio Grand train to begin his medical career in Rifle, then a town of less than a thousand. At about the same time, E. Dene Moore, D.O. started his practice in Rifle. In those days, allopaths and osteopaths usually viewed each other with suspicion. Not so with these two hard working doctors. They were good friends and were each other's doctor. In 1909, Clagett's wife



Architectural Drawing of Pioneer Hospital in 1949

substantial hospital. They raised the funds to match the available Hill-Burton funds. The county commissioners deeded the land of the old County "Poor Farm" and by 1955, they opened their new 22,00 square-foot hospital now called Valley View Hospital. Forty years later, they added a 55,000 square-foot wing costing \$8,300,000. Components of the new wing included an outpatient surgery, a Family Birthplace, Radiology with MRI and CT scanner, Occupational Therapy and a new laboratory. The hospital has 474 full time employees and 54 physicians on the medical staff. A dream come true for Dr. Nutting.

Traveling further west on Interstate 70, we pass through New Castle and Silt and stop at Rifle, a town of 4,700 with its own unique history. Shortly after the turn of the century, young Oscar Clagett, M.D.

presented him with a son, Oscar T. (they called him "Jim"). Clagett and Moore worked hard, taking health care into the home and winning the hearts of many. Young "Jim" watched his father and decided to follow his footsteps. After graduating from the University of Colorado with an M.D., he started practice in Glenwood Springs. "Jim" had grander dreams, however. He left Glenwood for a surgical fellowship at the Mayo Clinic. He was initially told that he had come from an inferior school and was not ready for the Mayo Clinic. A letter from his father, however, reassured him that Auntie Hills, the town mystic and seer had predicted that he would get a marvelous offer. So he persisted and was accepted by the Department of Surgery in spite of

(Continued next page)

his unimpressive background. O.T. Clagett stayed on at the Mayo Clinic after completing his fellowship in 1940 and became a world famous thoracic surgeon with many honors including chairmanship of the American Board of Thoracic Surgery and Fellowship in the Royal College of Surgeons of Ireland.

While Clagett the younger was becoming famous at the Mayo Clinic, Dr. Clagett the elder was making his mark in Rifle. Now that World War II was over, he wanted his community to have a hospital. He traveled throughout western Garfield county persuading the citizens to vote for a hospital district that would provide a tax base for a hospital in Rifle. This much loved

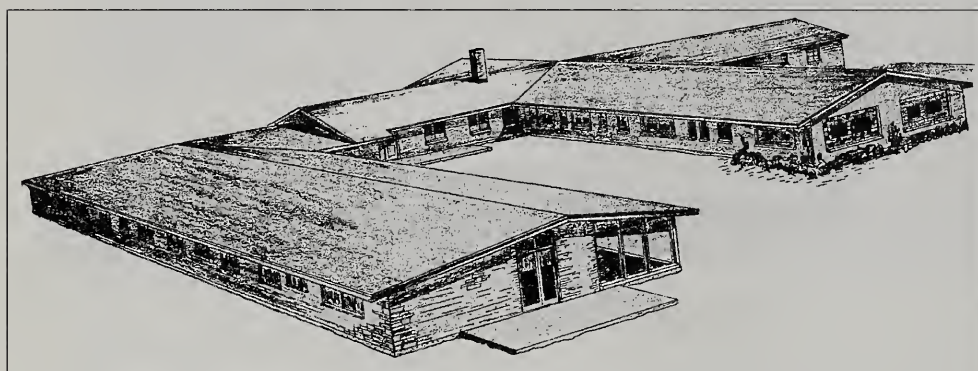
District, which Dr. Clagett had established, built the E. Dene Moore Memorial Home, the Grand River Rehabilitation Center, the Grand River Medical Clinic, the Grand River Prenatal Clinic and the Grand River Home Health and Hospice. Both father and son left important contributions to their communities.

If we travel north from Rifle on State Highway 13 for about 60 miles, we reach the beautiful valley of the White River and Meeker, current population 2,098 and the county seat of Rio Blanco county. As early as 1910, citizens had planned for a community hospital, but nothing came of it. Actually, one of the first buildings in Meeker was called Government Hospital, apparently built in 1879 by the U.S. Army during the Indian hostilities. The community used the building for

because there was not a hospital available. But in spite of his generous offer, the commissioners were slow to take any action. By July, 1946, the commissioners had not acted on his proposal, so Mr. Fairfield gave the county a new ambulance especially outfitted for use on the rural roads of Garfield county. In August, 1947, 18 months after Fairfield's original offer, the county commissioners appointed a County Hospital Board with the responsibility to plan and build a county hospital. Finally!!

The Hospital Board selected a site, hired an architect and set about making the dream of a hospital become a reality. Initially they planned to call it Fairfield Memorial Hospital, but Fairfield asked that it be named The Pioneers Hospital to honor the pioneers in the White River valley. It was truly a community project. A contractor was hired to supervise the work of all the volunteers and paid workers in the building project. The county road crews did the excavation. One man offered stone from his quarry. Several gave land for the project. Men gave hours of labor, women brought food and drink to the workers. Other women took courses in practical nursing given by Mesa College. Many others, including school children spent many hours raising additional funds. Four years after Freeman Fairfield had started his campaign for a hospital, on December 10, 1950 the new \$300,000 hospital was dedicated. The whole county celebrated.

How has Pioneers Hospital, the pride of Meeker, fared since that auspicious opening? There have been good and bad times. Freeman Fairfield's continued generosity certainly helped. A gift from the Warbridge family enabled the hospital to build a 29 bed convalescent wing. Fully occupied with a waiting list, this addition has been and important source of revenue. Physicians, however, were crucial to the enterprise. This was a small, isolated community and did not appeal to many physicians, and a number served the hospital for brief



Architectural Drawing of Pioneers Hospital in 1962

physician was successful in his campaign. Matching funds could now be raised to facilitate receiving Federal Hill-Burton funds. With the aid of dedicated volunteers and a contractor, a World War II housing project was remodeled into a hospital; Rifle Community Hospital opened on March 25, 1954. Dr. Clagett, now past 70 could now relax. This wonderful gift to the community was now complete.

Rifle was growing; it had become the "Oil Shale Capital" of the world, and the hospital was soon inadequate. After more fund raising, a entirely new and larger 32 bed hospital was built which was dedicated on December 16, 1962 as the Clagett Memorial Hospital. Since then, The Grand River Hospital

their first school. By 1946 the community began thinking about a hospital. Rio Blanco county was one of three counties in the state without a hospital. In early 1946, Mr. Freeman Fairfield, who had made his fortune in the oil fields of California, returned to his home town of Meeker. He appeared before the county commissioners to offer both land and \$30,000 if the county would build a hospital. He presented a persuasive argument to the reluctant commissioners, pointing out that there was an opportunity to purchase surplus medical equipment from the armed services if they acted quickly. Fairfield had a strong need for a hospital. As a child, he had watched his mother die at home of peritonitis from a ruptured appendix



Pioneers Hospital 1998

periods. Many found the practice too demanding. There were exceptions: Dr. Earl Ryan who stayed for 18 years and Dr. Dave Eskelson who practiced for 27 years. Dr. Eskelson was one of those rare, old fashioned doctors who did everything! Major surgery, obstetrics, (over 4000 deliveries), pediatrics, geriatrics, cardiology, (he established a coronary care unit), home visits, on call for the hospital emergency service, insurance exams, everything! He must have been tired, but he did not show it. He kept the hospital's beds occupied. After Dr. Ryan left in 1978, he was often alone until two new physicians came to town. Dr. Eskelson retired in early 1991. In that same year, the hospital board had asked the county for \$1,986,522 and the county commissioners could only come up with \$574,000. Rio Blanco county is a poor county.

The future of the hospital seemed to be in jeopardy. The upshot was increasing conflict and bitter recrimination between the physicians, the staff, the administration, the board and in the community. It was a bitter and painful time. The physicians angrily resigned in frustration, leaving the hospital totally dependent on locum tenens physicians. These were black days for Meeker.

As the hospital was limping along with locum tenens, one of those physicians was Dr. David Steinman, formerly on the faculty of the Department of Family Medicine at the University of Colorado. He liked the town and the hospital and decided to stay. With David Steinman's quiet, even handed leadership and the help of new, creative administrator and a hard working board, the crisis was

resolved. Two physicians have joined Dr. Steinman: first Dr. John Ryndfleisz and then Dr. Victor Mihal. With a stable physician base, the hospital has recovered. Indeed, a \$2,648,000 new capital improvement and construction project is now underway. A new Meeker Family Clinic now provides a state of the art, comfortable working space for the three physicians and two nurse-practitioners. Pioneers Hospital is ready for the 21st Century.

There are interesting stories in other small communities such as Haxtun, Holyoke, Lajara, Eads,

Rangely, Springfield and Wray, all frontier communities facing their own crises in primary care each in their own creative ways, and all dependent on the physicians who serve them. None will be like Dr. Eskelson, but some may be like Dr. Steinman. When Dr. Eskelson was interviewed by Holly Herman and Angie Woodward from the Meeker high school composition class, he told them: "... they wanted to throw this retirement party for me but they did not need to. I've already been repaid for my efforts, and while I can't exactly say it's been fun because of the business of medicine deals with tragedy, the most I can say is that we walked the path together. As far as I am concerned, the honor or whatever you call it, has already been given. I've been invited to share the tragedy and the joy, and there aren't very many people that have the privilege of sharing intimately the good times and the bad with families. That in itself is the biggest satisfaction."

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Worried by the uncertainty of the stock market? Ever wonder if you'll wake up one morning to find the growth bubble has suddenly burst? Maybe you should consider an investment based on a solidly established phenomenon: The number of elderly is increasing every year, and will continue to do so for the next two decades.

The "age wave" is just beginning to hit the Denver area. Facilities to house the disabled elderly are going to be more and more in demand. We at **Affirmative Aging Centers LLC** are in the process of developing a 62-bed assisted living center in Evergreen, one of the metro area's most affluent markets.

We've received conditional approval on a \$4.233 million loan that's guaranteed by the Federal Housing Authority. Now, to build **Evergreen Commons Assisted Living**, we need to assemble equity. Investors can expect an excellent rate of return that's partially tax sheltered. Call us today for detailed information.

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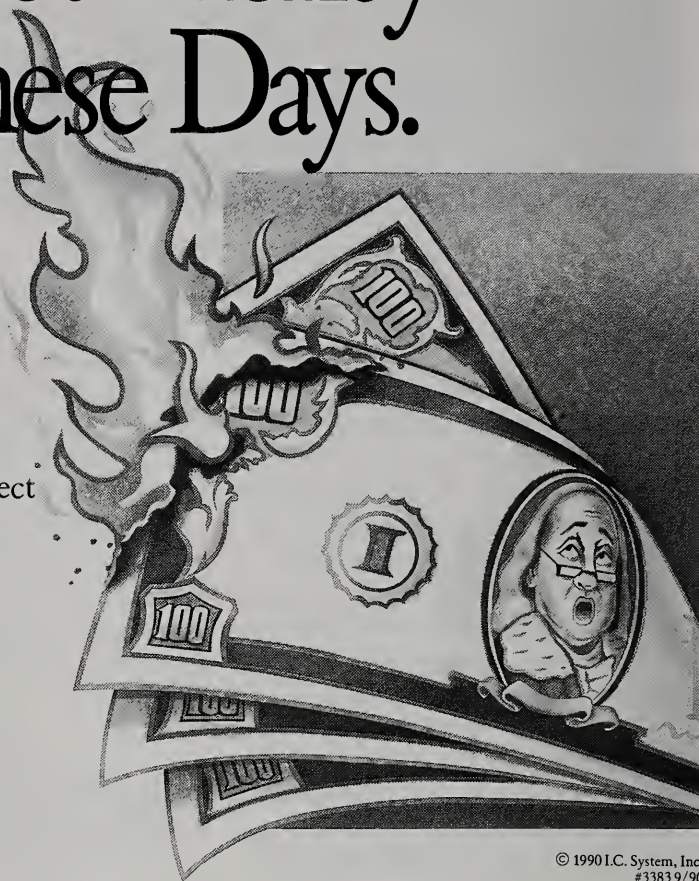
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CALL FOR NOMINATIONS 1998 Wyeth-Ayerst Physician Award for Community Service

The Colorado Medical Society is pleased to announce that once again the Society will be cooperating with Wyeth-Ayerst Laboratories in presenting the 1998 Physician Award for Community Service. This is an opportunity for you, CMS members, to honor one of your fellows who has contributed in an outstanding way to his or her community. The criteria are simple, as follows:

- The recipient must be a physician licensed within Colorado.
- The recipient must be living; no posthumous awards are permitted.
- The recipient may not have received this award previously.
- The recipient has completed an outstanding record of community service which reflects well on the physician.

Each nomination made must be accompanied by a personal data sheet describing the nominee's community work. Supporting documents (testimonial letters and statements, published data, etc.) should also accompany the nomination. None of the materials will be returned.

Nominations must be received by June 1, 1998. It is very important that **all nominations and supporting material be mailed to the following address:**

**Confidential Awards Committee
Colorado Medical Society
P. O. Box 17550
Denver, CO 80217-0550**

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Copic Going Strong, Growing Strong *Highlights from Copic's 1997 Annual Report*

Many of you are already aware of the recent insolvency and liquidation of PIE Mutual Insurance Company (PIE) in Ohio. At its height, PIE controlled 30% of Ohio's \$263 million market for medical professional liability insurance. They insured more than 18,000 physicians in nine states. How could such a seemingly successful company fail so spectacularly? Their missteps and mistakes were many. Primary among them was the failure of PIE's Board of Directors to exercise its duty to monitor the company's financial condition.

With that in mind, I thought that readers of *Colorado Medicine* might appreciate a review of Copic's financial results for the past year. Due to space limitations, I can only touch on the highlights here. For more in-depth information, I would refer you to Copic's 1997 Annual Report, which was mailed to all insured physicians in late April. Copies of the Annual Report are available upon request to Kathy Brown, Director of Business Development, at 303-930-0490 or 800-421-1834, ext. 2490. You may also e-mail your request to kbrown@copic.com.

Copic was fortunate in 1997 to benefit from the unprecedented growth of the stock market. Our investment income rose by 27.6% over 1996. From this investment income, we pay

all of Copic Insurance Company's operating costs. Since our investment income well exceeds our operating costs, premium dollars are used only to pay losses - not salaries, benefits, etc.

Sustained growth in our surplus permitted the introduction in September, 1997, of "Copic Care" long-term care coverage as a valuable policy enhancement for eligible insured physicians.

We declared another \$6 million distribution, payable in 1998. This brings to \$52.2 million the total returned to policyholders since 1990. Distributions over the past eight years have averaged 13% of premium volume.

Our loss ratio (the percentage of premiums used to pay losses and loss expenses) dropped from 84.0% in 1996 to 73.3% in 1997 - a 10.7% improvement. Credit for this achievement belongs to the Claim and Risk Management departments for their efforts to obtain favorable defense outcomes, minimize amounts awarded through adjudication or arbitration and equip physicians with real-world tools and techniques to manage risk and reduce the likelihood and severity of a claim or suit.

We saw a related improvement in our net underwriting gain (premium income minus losses and loss expenses for the same period) - up more than \$3.7

million, for an eightfold improvement over the 1996 underwriting loss of \$450,000. This is due primarily to reserve takedowns, adjusting our loss reserves to account for favorable loss developments from prior years.

Our 1997 overall operating ratio of 60.0% represents an improvement of 16.9% over the 1996 ratio of 76.9%. The overall operating ratio is a measure of an insurer's operating results for a given time period and takes into account premiums, losses, expenses, and investment income. The lower the percentage, the better the results. Every department at Copic Insurance Company can take pride in its integral contribution to this demonstration of our efficiency.

The Copic Board monitors all of these financial parameters and many more, fulfilling its responsibility to ensure that the company you've counted on in the past will be there for you well into the future. Copic has maintained an A- (Excellent) rating from A.M. Best since 1994. You may rest assured that regardless of the direction we may choose, we will remain steadfastly focused on our mission to serve your needs while remaining financially strong. We greatly appreciate your continued trust and confidence in us, and we welcome your questions and comments.



COMPONENTS

Retirement



Brad Darley

Brad Darley has served as Executive Director of the Arapahoe Medical Society and Arapahoe Medical Foundation for the past 15 years, but that in no way was that the beginning of his career in the health arena. His tenure with AMS/AMF was preceded by 23 years of hospital and clinic administration.

To prepare for his career, Brad majored in Biological Science and Chemistry at the University of Colorado School of Arts and Science, and received his bachelors degree from the Colorado State University in Fort Collins. He then achieved a Masters Degree in Hospital Administration from Washington University in St. Louis.

Brad began his career in 1962 as an Intern in Hospital Administration at Colorado General. In the late 60's he was the Assistant Administrator of the 570 bed Cleveland Clinic Hospital. He then accepted the

position of Associate Administrator of the 84-physician Straub Clinic in Honolulu, Hawaii. He returned to the Denver area in 1971 as the Associate Administrator of Swedish Medical Center, at which time he began a long tenure of working with the medical community in South Metro Denver. In October of 1977 he became the Administrator of Swedish for all operations of the 320 bed community hospital. From 1980 through 1983 he was the Senior Vice President for Operations at the Children's Hospital in Denver.

While Brad was at Swedish, the medical staff at Porter and Swedish had formed a "Combined Medical Staff" and one of Brad's assignments was to consolidate all Obstetrics at Swedish and transfer Pediatrics to Porter. The dynamic and wholesome experience of working with the physician community lead Brad back to South Denver and the AMS after being the Chief Operating Officer at Childrens Hospital.

In addition to AMS, the Arapahoe Individual Practice Association (IPA) and AMF were very involved in the development of an HMO and PPO: Principle Health Care United. The Foundation owned a one third interest in the companies that managed Health Care United. IPAs based at all the major component medical societies joined together to create a physician controlled managed medical care system of over 2,000 physicians.

AMF did not have the capital to invest in the expanding HMO and as a result was forced to sell its one third interest to an affiliate of Swedish Medical Center. By doing so,

AMF was able to reduce some of its considerable debt. Unfortunately, the future of Health Care United was a different scenario as it went into bankruptcy, resulting in a significant financial loss to the physicians and a law suit. The few remaining assets of the IPA went to the Doctors Care program.

Brad, Jane Howard, and some dedicated volunteers managed the Doctors Care program out of the Society offices for several years before the program was relocated to Littleton.

With the demise of the Combined Medical Staff the second floor became difficult to rent once the Society Credentialing program was discontinued. The AMF building was sold which made the Foundation debt free for the first time in its history.

AMF also administered a Credit and Collection business which was sold, and continues to administer the Medical Telemessaging Service, which is thriving; it currently serves approximately 800 physicians as well as other medical clients, and remains the revenue source for the foundation.

Brad and his wife, Herta, are well prepared for his retirement, having already established a winter home in Arizona. In addition, Brad has sufficient interests and hobbies to keep him very busy; they include: bicycling, fishing, hiking, tennis, golf, various forms of dancing, and thoroughly enjoying his grandsons. We wish him a most enjoyable and fulfilling retirement after his many years of service to the health care industry.

AMA Solutions to Sponsor Entrepreneurship Seminar for Physicians

AMA Solutions, a subsidiary of the American Medical Association, is sponsoring a seminar,

Physician Entrepreneurship: Principles, Practices and Tactics for New Healthcare Ventures

WHO: Presented in conjunction with Northwestern University's Kellogg Graduate School of Management, focusing on business skills physicians need to be leaders in today's volatile healthcare market. Craig Samuels, the conference organizer, points out that "physicians are increasingly being asked to participate in capitation and other business arrangements which may put them at financial risk. As a result, physicians need a working understanding of business concepts to understand the implications of these ventures."

WHEN: May 17 - May 20, 1998

WHERE: North Shore Doubletree Hotel in Skokie, Illinois

WHY: With the rapidly changing delivery of healthcare services in the United States, physicians are confronting new challenges that affect not only their financial viability but even basic survival.

For more information about the seminar, including registration fees and a complete conference program, call 800-366-6968 or visit www.amsolutions.com

You're too busy practicing medicine to play politics

Every day you see the effects of health care reform on your practice. Every day you promise yourself that you will become more involved and help shape the future of medicine. But the truth is that sometimes you are just too busy.

Fortunately you have COMPAC. Legislators are becoming aware of and educated by organized medicine. However, the Campaign Reform Amendment and legislator turnover in both Houses in 1998 may dramatically affect the legislative advances made for you and your patients.

Join COMPAC today and become personally involved in the future of health care in Colorado. Then rest assured the voice of organized medicine will continue to be heard at the state legislature. For information call (303) 779-5455, ext. 2410 or 1-800-654-5653.





BOOK REVIEW

by Ben Eiseman, MD

"The Roots of Healing are in the Earth" has a particularly important message to both patients and doctors in this age when commercialism is in direct conflict with professionalism in the doctor patient relationship.

The theme of this unique book written by a practicing physician from Carbondale, Colorado is that physicians should be trained and practice the art of teaching patients how to preserve health and to live a full and profitable life rather than simply to fight disease.

The book is divided in two parts: the first is an exhaustive review of quotations and commentaries from dozens of philosophers and savants concerning the sources of happiness by living a full life. Evans has been impressed by the writings of Schweitzer and Salk and centers his commentaries on their philosophy extolling the virtues of the simple truths known to and practiced by primitive people. This Rousseau-like philosophy I must say has been tarnished by the disgraceful performance of the untutored natives held in such high esteem by Schweitzer and the author when the peoples of Central Africa were given their freedom and

independence. No sooner free than began genocide on their neighbors. But this criticism aside, these many quotations, strung together by an almost free flow of consciousness emphasize the importance of health rather than the absence of disease as the goal of physicians practice. A preponderance of the quotations are what most of us consider "exotic" sources such as Native Americans, the middle east and from various

oriental philosophers and religions.

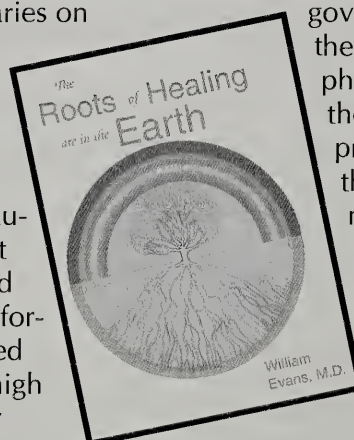
Then comes Part II containing the message to doctors and patients. Evans quite properly emphasizes the importance of learning how to maintain health rather than merely to stop disease. He takes the next step in suggesting that the physician should teach the patient how to enjoy full health and live a full life using the philosophy he so liberally defined in the first portion of the book.

There will be those clinicians so involved in filling out HMO forms and seeing that they adhere to

government regulations that they find little time to add philosophy to the message to their patients. Evans as a practicing doctor knows that, but his thesis is that more good probably can be done by the former than by administering pills or performing operations of questionable requirements.

This book has a particularly important message to both patients and doctors in this age when commercialism is in

direct conflict with professionalism in the doctor patient relationship. Physicians are fighting a losing game in trying to protect professionalism. This book emphasizing the classic role of the doctor in improving the quality as well as the duration of life sheds a unique emphasis on how this traditional role can be achieved by reverting to some of the lessons of what is commonly thought of as "primitive" cultures.



"The Roots of Healing are in the Earth"
by William Evans, MD



by David P. Halsch
Senior Financial Consultant

Editor's Note: This feature is presented as a CMS Member Service in connection with the CMS/Merrill Lynch Physician's Financial Program.

Running a successful medical practice has never been more complex. As a successful physician and business owner, you know many critical issues and details are involved in your success. Your practice's success depends not only on providing quality patient care, but also how you:

- manage your money
- reward your employees
- respond to regulations
- react to competitive pressures; &
- react to an ever changing health care industry.

Dealing effectively and efficiently with all of these issues will allow your practice to prosper for years to come. Your first step to addressing these issues is through a plan, helping you to gain an overall perspective of your practice's current health. Moreover, a plan can provide you with insight into the future of your practice and allow you to revise strategies and make necessary adjustments to ensure continued prosperity. To be comprehensive, a financial plan should cover the issues that affect the financial resources of your practice, including trends in the health care industry, your practice's organizational structure, cash management, financing short-term investments, business insurance protection, employee benefit programs, retirement planning, succession planning and estate planning. A comprehensive financial plan should also examine your practice's historical financial performance in relation to other practices of similar size. Taking this kind of comprehensive

approach to your financial planning is important because it can help you:

- identify your financial needs
- avoid overlooking important areas of concern; and
- prioritize goals for your practice.

A Comprehensive Financial Plan Should:

- Provide an overview of your financial situation. It should set the stage and answer the question, "Where are you now?"
- Focus your attention on the achievement of future goals. It should help you answer the question, "Where do you want to be?"
- Help you and your advisor set priorities and establish strategies for achieving specific financial goals. In other words, "How can you get there?"

Because your practice's financial health can be substantially affected by your business environment, some plan preparers present information that helps you understand the outlook for your medical specialty. This may include analyses of growth rates, business potential, factors affecting growth in your industry and region, and relevant recent or pending legislation.

Once your plan is complete, you will need to put it into action. Many financial advisors offer support throughout this process and call in any specialists you will need. For example, a financing specialist may be called upon to help structure a loan transaction, or a succession planning specialist might be contacted to assist in the sale or transfer of your practice.

Financial Planning to Ensure a Healthy Practice

Conditions change rapidly in the financial industry. Changes in tax laws, business regulations market conditions and other factors continually spur the development of new, innovative financial products and services. By doing so, you will help to ensure the continued growth and prosperity of your practice.

Medicare Provider Service functions transferred to ND

The Medicare Carrier for Colorado, Blue Cross and Blue Shield of North Dakota, has transferred the responsibilities of their Provider Service Department (phones and correspondence) from the Golden office to their office in Fargo, North Dakota. This change was originally planned to take affect this summer, however, due to a loss of many of their key employees the level of service had begun to deteriorate. This drop in performance, combined with the fact that the Fargo office was already staffed for the additional work, prompted the Carrier to make the change in early April. Physicians' offices should **not** be impacted by the switch. If you do encounter problems, please let Marilyn Rissmiller at CMS know. She can be reached at 779-5455 or 1-800-654-5653, ext. 2428. Following are the updated telephone numbers and mailing address:

Physicians' offices within the metro area should continue to use 831-1221;

Physicians' offices outside the metro area should use (701) 277-6565;

Correspondence and appeals should be addressed to: Provider Service Department, Medicare B, P.O. Box 6028, Fargo, ND 58108-6028.

Medical Informatics Education Series for Doctors Planned

The CMS Medical Informatics Committee is designing a CME series. Through on site visits (yes, field trips), physicians will be provided hands-on, highly interactive information relative to use of computer technology in medical practice. The event will be kicked off with attendance at the Denver Medical Library Medical Informatics Fair on September 25-26. Details about inclusion of the Fair in the package will be provided at a later date. The series will involve 5 Saturday mornings, beginning Oct., 10.

The sites to be visited are:

Kaiser - The integrated medical record: How does it work? Can it work for you?

Denison Library - This introduction to the Internet and WWW will be tailored to the interests and skill levels of the registrants (for example, equipment needed, connecting to the net and web, starting points for clinicians, effective searching/filtering skills, etc.). If

more advanced skills are needed or desired, the instruction might include software options for multimedia sites and locating specialty web sites.

Medical Group Management Association (MGMA) - How to find practice management information and resources. How to locate cost management and patient satisfaction training via the Internet.

The Center for Human Simulation - How to access the Visible Human for use in your practice. Anatomy utilizing virtual reality (the latter to be tailored to interests of the registrants).

Watch Colorado Medicine for details about this exciting educational series. Contact Suzi Shevell: 930-0407; 1-800-654-5653, x2407; suzi_shevell@cms.org or Lorraine Heth 930-0409; 1-800-654-5653, x2409; lorraine_heth@cms.org if you absolutely, positively need more information NOW!



<http://www.cms.org>
Find out
what's happening in
Colorado health care



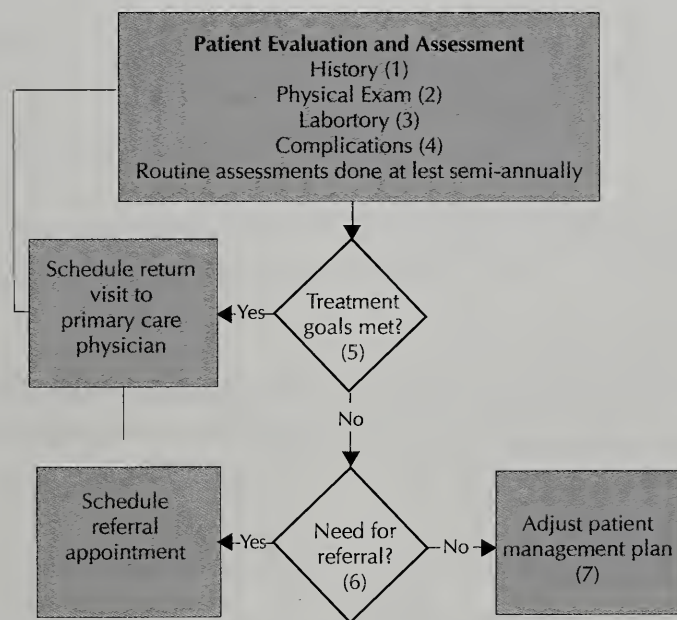
CMS to Hold Educational Conference for Collaborative Data Project on Diabetes

In conjunction with the Collaborative Data Project on Diabetes (see April, 1998 Colorado Medicine insert), CMS will hold an educational conference on June 26, 1998. This conference, sponsored by Copic Insurance, will provide physicians with information on how data can be used to improve the treatment of patients with diabetes. The program is the product of a working group of CMS members and nine managed care organizations (MCOs). The conference will assist physicians in analyzing profiles on their treatment practice patterns for diabetic patients. It will be held at the new, state-of-the art W. Gerald Rainer, MD, Auditorium at St. Joseph's Hospital in downtown Denver. CME credit and one Copic ERS point will be available to those physicians attending the conference.

Caring for Diabetic Patients: What Works and What Doesn't, is the culmination of more than a year of work by CMS and MCOs to develop data profiles which physicians can use for educational purposes to improve their practices. Participating plans include: Aetna U.S. Healthcare, CIGNA, Colorado Access, HMO Colorado, Kaiser Permanente, Pacificare, Qualmed, Sloans Lake Managed Care and United Healthcare. During the past few months these plans mailed practice profiles to primary care and specialty physicians around the state. These profiles were generated from administrative data and analyze four different processes of care.

The conference will also analyze the Colorado Clinical Guidelines Collaborative (CCGC) for the

Treatment Algorithm Continuing Care of the Adult Patient with Diabetes Mellitus



Numbers in the parentheses are explained in the annotation points on the following pages

Note: These clinical guidelines are designed to assist clinicians in treatment of adult patients with existing diabetes. "Adult" for purposes of the guideline generally refers to persons over age 21. The guidelines are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. Accepted January, 1998.

Treatment of Diabetes Mellitus. These guidelines provide the basis for which the Collaborative Data Project on Diabetes devised a way to generate profiles.

The four main objectives of the conference include:

- 1) Evaluate the standards of four processes of care;
- 2) Provide physicians with the opportunity to aggregate data from the reports they obtain from multiple MCOs to develop a profile of their practices;
- 3) Analyze the CCGC diabetes guidelines; and

4) Develop ways to improve patient outcomes through system accountability and patient education.

Expert primary care and specialist physicians will discuss the project, the guidelines and the data. A panel of high performing physicians will present their practice techniques. Mark the date on your calendars now, June 26 from 8 am - Noon, and look for registration information in the mail in coming weeks. Contact Chet Seward (Chet_Seward@cms.org) in the CMS offices at (303) 779-5455 or 1-800-654-5653 for more information.

Medicaid fiscal agent transition rescheduled

The Colorado Medicaid fiscal agent transition from Blue Cross Blue Shield of Colorado (BCBSC) to Consultec, planned for June 30, 1998, is being delayed until October 1, 1998.

The following activities are planned during the transition:

- Consultec will post information on a new Consultec Internet Web Page. The Web Page is available now, though it is still being constructed and may be accessed at <http://www.consultec-gcro.com>.
- Providers and software vendors will be able to conduct electronic claims submission testing beginning in April 1998.
- Consultec will conduct transition workshops for providers in August and September. The workshop schedule will be distributed in mid-July.
- Transition startup packets will be mailed to providers to assist them in making the transition to the new fiscal agent.
- Updated interactive Automated Medical Payments (AMP) system software will be sent to providers who currently have Medicaid AMP software.

Consultec's Provider Services Phone Center will not begin operation until October 1, 1998. For claim submission assistance and claim inquiries, providers should continue to call Medicaid Communications at BCBSC until October 1, 1998.

A Unique Fringe Benefit For CMS Members



Buying or Leasing a New Car???

The **Colorado Medical Society** now provides a professional fleet management service to assist members throughout the state when purchasing or leasing a new vehicle. This service provides valuable vehicle information such as factory invoice costs, available options, technical data, consumer reports, etc.

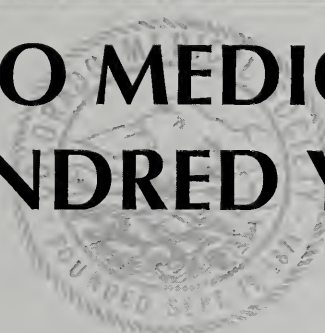
Once your selection is firm, your purchase or lease will be arranged at **prices normally available only to large corporate fleets**.

Colorado Medical Society has endorsed Rocky Mountain Fleet Associates as a CMS member service, based on the satisfaction of the many physicians who have used their services over the past several years. These physicians have reported excellent results, **usually with savings of more than \$1000 from even the best negotiated showroom price**.

For more details, call **(800) 864-4388**. In Denver, **753-0440**.

Colorado Medical Society

COLORADO MEDICAL SOCIETY ONE HUNDRED YEARS AGO



***IN 1898**

Colorado Medical Society, then 27 years old, had 511 members.

***IN 1998**

Colorado Medical Society, now 127 years old, has 5,260 members.

In 1898, Colorado had been a state only 22 years, and the economy and population base was chiefly agricultural and mineral, which meant that the majority of people were working with their hands in decidedly rural parts of the state.

In 1998, one hundred years later, a large percentage of Colorado's population still lives in rural areas, few of whom depend on agriculture or mining economies, but who still have one major factor in common.

Neither then nor now do 100% of Colorado's residents have necessary and proper medical treatment at hand; both then and now, they suffer a shortage of medical practitioners domiciled in these rural areas of the state.

What IS different about 1998 is that Colorado Medical Society has created
C.R.O.P. (Colorado Rural Outreach Program)

to fulfill the medical needs of the state's many rural areas, but your help is needed. CROP Foundation is anxious to have your help in this program to place physicians in the rural areas of Colorado.

***IN 1998**

there is no good reason why CMS can't help supply the physicians necessary to the rural populations through CROP (Colorado Rural Outreach Program) Foundation, if you will participate by contributing your time and knowledge.

Please...call or write for details on how you can help.

Contact the Foundation office at (303) 930-0407 or 1-800-654-5653, extension 2407



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PUEBLO MULTISPECIALTY GROUP SEEKS PEDIATRICIAN to expand busy two physician dept. Competitive salary program, full benefit package, incentive plan, and relocation assistance. Contact: Jerald Erstgaard, Exec Dir Pueblo Physicians, PC, 2002 Lake Ave, Pueblo, CO 81004. (719) 560-7123, (800) 234-1099. 04/0498

PUEBLO MULTISPECIALTY GROUP seeks family practitioners for a 5 physician dept. and urgent care. Competitive salary program, full benefit package, incentive plan and relocation assistance. Contact: Jerald Erstgaard, Exec Dir Pueblo Physicians, PC, 2002 Lake Ave, Pueblo, CO 81004. (719) 560-7123, (800) 234-1099. 04/0298

EXCELLENT OPPORTUNITY for an enterprising BC or BQ Family Physician not wanting to practice in a large corporate setting; to join a two-man, well established practice in Lakewood, CO. FAX resume to (303) 232-9247. 03/0398

BOARD CERTIFIED OCCUPATIONAL PHYSICIAN, Metro-Denver, experience necessary. Physician owned and managed. Competitive salary and benefits. Fax resume to (303) 373-4501. Call 373-4456. 05/0398

BOULDER - EXCELLENT OPPORTUNITY for Board Certified MD in Urgent/Family/Occupational care. Reply to Medical Director, Meadows Medical Center, PC, 4800 Baseline, D-106, Boulder, CO 80303. (303) 499-4800. 04/0298

SEEKING BE/BC ENDOCRINOLOGIST to join large multispecialty group. Scenic community in foothills of Rocky Mountains located 50 miles north of Denver. Send CV to Jolene Yates, Physician Recruiter, PO Box 830, Loveland, CO. 80539-0830. 04/0598

◆ PROFESSIONAL OPPORTUNITIES

BEAUTIFUL ROCKY MOUNTAIN - busy established family practice affiliated with Boulder Community Hospital seeks a Board Certified Family Practitioner with an interest in complimentary medical approaches. Please send your resume to Boulder Community Hospital, Personnel, PO Box 9019, Boulder, CO 80301-9019.

06/0298

SEEKING BC/BE INTERNIST to join a two-physician private primary care clinic. Scenic communities in foothills of Rocky Mountains located 50 miles north of Denver. Send CV to Jolene Yates, Physician Recruiter, PO Box 830, Loveland, CO. 80539-0830. 06/0298

CRESTED BUTTE - EXCELLENT IMMEDIATE OPPORTUNITY for Urgent/Family Practitioner. Orthopedic background desirable. Full or part-time. Thomas Moore, MD, PO Box 1998, Crested Butte, CO 81224. Call (970) 349-2677.

02/0498

DENVER OB/GYN - Two MDs needed for thriving two location practice. Salary neg. Experience 1 to 3 years. OB and Surgery. Call is 1 in 10. Partnership possible, call (303) 946-1909. Fax CV to (303) 986-1509. 01/0598

◆ SITUATIONS WANTED

LOCUMS: Two dependable BC EM MDs, 4 and 19 years experience, willing to absorb seasonal peaks, episodic vacancies, part of full time slots, CO licensed, long-term potential. No management fees. (817) 485-8866. 11/1197

◆ SITUATIONS WANTED

BOARD CERTIFIED ORTHOPEDIC SURGEON with 30 years experience in general orthopedics, trauma, arthritis, pediatric orthopedics, sports medicine, joint replacement, spinal, hand, and geriatric orthopedics, seeking 1 to 3 days a week in a family practice, mixed specialty or orthopedic office doing office orthopedics. Provide prompt care, pleasing orthopedic patients in your office setting. Reply to CMS, Box 3, PO Box 17550, Denver, CO 80217-0550.

06/0298

◆ SERVICES

THE COLORADO INDEPENDENT PRACTICE NETWORK is an affiliation of physicians who work in whole or part on a fee-for-service basis. Our goal is to provide mutual support and create a network of doctors that patients can choose when they want an independent evaluation. For information call 789-4949.

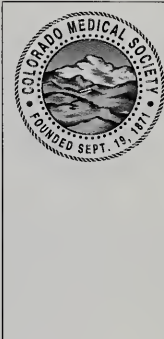
LOCAL LOCUMS is a Denver-based medical practice dedicated to providing quality locums coverage to Colorado family doctors. If you need to be away from your office or want to expand your practice without the risk and expense of hiring a new partner, we'd be happy to talk to you about how we can help. Please call Dr. Sheldon or Dr. Sowell for more information at 789-4949.

01/0598



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◆ FOR SALE OR LEASE

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DENVER TECH CENTER - Space available (Holly & Orchard) Multi-disiplinary office space available. Satelite or full time office space. Rent, utilities, advertising, billing for flat fee please call the office manager Diane 770-4424 (day) or 741-3843 (evening).

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01/0598

MEDICAL OFFICE SPACE TO SHARE with audiology practice. Renovated 1,050 SF across from Swedish. Great for physician or paramedic needing additional space. \$515/mo. Kelly Halligan, 426-0633 at Plaza de Medicos.

03/0398

◆ PRACTICES FOR SALE

PEDIATRIC PRACTICE FOR SALE IN FORT COLLINS, CO. Grossing more than \$420,000 per yr, large practice next to Poudre Valley Hospital. Sudden physician illness forces sale of practice. Inquiries to MD attn: Susan Ricci, 1260 Doctors Lane, Fort Collins, CO 80524. Phone (970) 484-9175, fax (970) 484-9592.

04/0298

FOR SALE - Well established solo general practice in Littleton. Last three year average annual colletions 330,000 with no O.B., hospitals or nursing homes. Contemporary 1,700 SF office space potential for additional adjacent space. Will consider various options. Reply to CMS, Box 3, PO Box 17550, Denver, CO 80217-0550.

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◆ MISCELLANEOUS

SURPLUS SUPPLIES OR EQUIPMENT?

Project CURE will pick up your surplus medical equipment, supplies, and books to recycle to third world countries. Call Dave Sattler at (303) 727-9414 or fax at (303) 727-8397.

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NEW-FOUND INCOME - Managed care eating up your income? Hundreds of physicians have accepted our business opportunity and tapped in to the multi-billion dollar nutritional products industry, adding up to \$50,000 monthly to their bottom line. How? Call (303) 271-7685 (*Independent Distributor for Wellness International Network, LTD.*)

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02/0498

◆ MISCELLANEOUS

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Personal debts you owe need not end up in court where only lawyers may win. Professional, confidential arbitration of student loans, mortgages, bank debt, equipment, credit cards, labs, etc. No fee unless settlement accepted by both client and the creditor. Call Carver Financial Services 970-690-6715.

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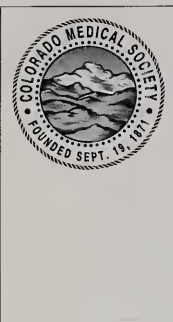
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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by Bill Pierson
Managing Editor

"There could be no better time than now. . ."

When I worked as a journalist outside the protective confines of health care and medical services it was an unspoken rule that we never included the word "suicide" in a story. There were too many competing philosophies which would not harbor the thought of someone taking his/her own life. We did all sorts of twists and turns to imply how the person died without speaking the fact that the person fully intended to end his/her life. Whatever we did, we certainly didn't write about why the person wanted to end life.

Suicide was much like "cancer" and "alcoholism" in those dark and basically uninformed days; we just didn't talk about them because of some stigma attached to them. As I look back I can't even remember what the stigma was.

The door opened long ago on that netherworld of mental illnesses and their effects. The openness has progressed so far as to prompt the U. S. Surgeon General to urge public discussion of suicide "and as it

relates to suicide." Dr. David Satcher said suicide should be an important health priority for the United States.

One of the examples of that kind of thinking was mention by the Surgeon General. He spoke of a town in the upper Midwest in which a 15 year old boy had taken his own life. Satcher said that the obituary in the local newspaper said only that the suicide victim "died at home" when, in fact, the boy had shot himself in the head with a pistol.

Dr. Satcher said "The people of this country desperately need to engage in an open and honest debate about mental health."

We know that the act of suicide hinges on some aspect of mental health, but that's only one facet of the subject. There are many mental ailments which may not drive the person to suicide, but can still make that person's life a "living Hell." The country has come far enough to include some parts of treatment of mental health under health insurance. It needs to go further to bring about a broad scale understanding of mental illness, its parameters and percussions. We are finally (almost) able to talk about alcoholism as an illness, and researchers are discovering what alcohol and other addictive drugs do to the human brain in deepening or broadening the person's addiction. Yet we treat so many of these illnesses as a social wrong and something for which the victim is blamed.

The Surgeon General has commissioned a study on the subject. There could be no better time than now, during May: National Mental Health Month. Clinics are

coming to grips with tenseness, anxiety, anxiety attacks, social anxiety, phobias, excessive worrying, sleeplessness and poor concentration. Any and all of these can be symptoms or indicators of a much more serious mental illness which is manifesting itself in these behaviors but which could mushroom at any moment into conditions which promote thoughts of suicide or other escape.

A few years ago in this space I wrote of my own minor experience with depression. What that experience gave me was a much greater appreciation for the persons who suffer clinical depression. I can see why many of them think there's no use in living. We, as a public at large allow this illness to go, basically unheeded, until we have victims of substance abuse, schizophrenia, bipolar disorder, dual diagnosis (substance abuse/mental illness) and major depression. Yes, I know there are many cases of mental illness (much more severe than these) which must be treated in residential facilities for the mentally ill. These we recognize and are aiding on a far broader basis. Now we need to recognize and start talking openly about the others and quit blaming the victim, leaving him or her to whatever brain wave whims might take over their lives.

Life is much too precious to us all. We mustn't leave so many people in the dark about an affliction which does directly or indirectly impact the majority of U. S. citizens.

Indeed, I hope you'll read the cover story in this issue. The subject is of vital importance to everyone.



COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

Volume 95, Number 6

1998

"Very few things in medicine are black or white.

One of the few is: If your heart stops, you die.

AM 98

Many areas of medical practice are gray areas, especially in these days of managed care."

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COLORADO MEDICINE

June, 1998

Volume 94, Number 6

"Very few things in medicine are black or white.

One of the few is: If your heart stops, you die.

AM98

Many areas of medical practice are gray areas, especially in these days of managed care.

In This Issue...

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*by Sandra L. Maloney
Executive Director, CMS*
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*by W. George Shanks, MD
President-elect, CMS*
- 198 **HANTAVIRUS BULLETIN:** Attention physicians... new developments in Colorado show dangers in all areas of the state.
*by Richard Hoffman, MD, MPH,
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and Nancy Madinger, MD
University of Colorado School of Medicine*
- 200 **1998 President-Elect's Planning Conference**
• Fraud & Abuse in the health care arena
• Managing Managed Care: Can it be done?
These were the principal subjects around which a productive conference flowed, with many questions and some likely answers. You'll see and hear more about these subjects at the CMS Annual Meeting in September.

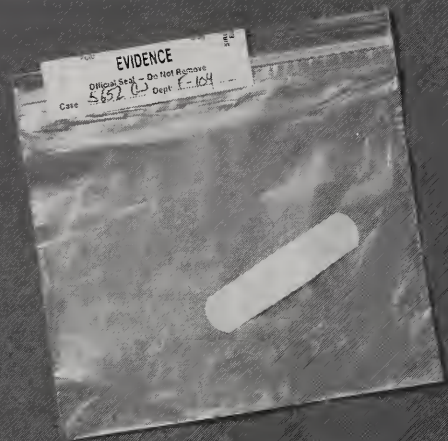


Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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AM 98

September 11 - 13, 1998
Steamboat Springs, Colorado

CALL FOR NOMINATIONS

The Colorado Medical Society will be holding elections at the Annual Meeting of the House of Delegates in September, 1998. CMS requests nominations for the following:

- CMS President-elect
- Vice-Speaker of the CMS House of Delegates
- American Medical Association (AMA) Delegates
- AMA Alternate Delegate

Dr. Richert Quinn has announced his candidacy for re-election as AMA Delegate.

Dr. Robert McCartney is running for re-election as AMA Alternate Delegate.

Dr. Sherri Laubach is a candidate for re-election as Vice-Speaker of the CMS House of Delegates.

If you are interested in becoming a candidate for any of the above offices, please submit your name and a current resume' to the CMS Executive Office, PO Box 17550, Denver, CO 80217-0550.

If you have any questions, contact either Sandra Maloney or Debra Jones at 303-779-5455 or 1-800-654-5653.

CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax®
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

Use of the Medical Treatment Guidelines for Cervical Spine Injury, Chronic Pain Disorder and Traumatic Brain Injury

The Department of Labor & Employment Division of Worker's Compensation & University of Colorado School of Medicine will present Medical Treatment Guidelines for cervical spine injury, chronic pain disorder and traumatic brain injury. There will be five sessions available. The seminar will include the opportunity to participate in interactive workshops to discuss the use of the guidelines for specific case studies. At the seminar you will receive a copy of the Workers' Compensation Rules of Procedure, Rules 14-20, including all of the Medical Treatment Guidelines and an update on the quality-improvement projects designed to evaluate the effectiveness of the Treatment Guidelines.

The University of Colorado School of Medicine designates this continuing medical education activity for a maximum of 7 hours in category 1 credit toward the AMA Physicians' Recognition Award. The Division of Workers' Compensation is applying for continuing education credits for other professional disciplines. If you wish to receive continuing education credits, you will need to pay for these credits the day of the seminar. Sign-up and payment, if applicable, will be handled at the seminar you attend.

Date & Location

August 14th	Golden
August 27th	Colorado Springs
September 17th	Grand Junction
September 25th	Denver
October 3rd	Denver

Agenda

8:00 am	Registration & Continental Breakfast
8:30 -noon	Morning General Session
noon-1:00 pm	Lunch (included in the fee)
1:00-4:00 pm	Afternoon Interactive Workshop

Instructors

Kathryn L. Mueller, M.D., L. Barton Goldman, M.D., Michael E. Janssen, D.O., Thomas G. Friermood, M.D., Richard L. Stieg, M.D. and Kenny Hosack, M.A.

If you have questions, contact **Washington Park Travel** at **(303) 777-8182**. The course fee is \$120.00.

Scientific American Medicine Launches Online Text

Scientific American Medicine launches online text of internal medicine on its new Web site SAM Online ([http:// www.samed.com](http://www.samed.com)). This new site provides health care professionals with immediate access to *Scientific American Medicine*. SAM Online features additional material not available in the loose-leaf or CD-ROM versions, such as fast-track updates, extensive online links, and supplementary text and illustrations.

Visit the free preview area on SAM Online. Current subscribers to *Scientific American Medicine* Loose-leaf or SAM-CD get free access to the Web site.

Society of Correctional Physicians' New President

Roderic D. Gottula, MD was installed as the new president of the Society of Correctional Physicians on November 8, 1997 at their annual meeting in San Antonio, Texas.

Dr. Gottula is a member of the Colorado Medical Society and an Assistant Professor at the University of Colorado Health Sciences Center, Department of Family Medicine. He is past president of Aurora-Adams County Medical Society, current chair of Aurora-Adams County Program Committee and member of the Board of Directors of Colorado Foundation for Medical Care (CFMC).

Dr. Gottula is former Chief Medical Officer for the Colorado Department of Corrections and has served as President of the Rocky Mountain Chapter of the American Correctional Health Services Association.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Root Cause Analysis for Health Care Professionals

June 15, 1998

Cherry Creek Inn

Denver, CO

Contact: Peggy McCreary at CHA

(303) 758-1630

Explore the Changing Roles of Health Care Professionals

June 16, 1998

Adam's Mark Hotel

Contact: Colorado Health Professions Pannel

(303) 832-1109

Colorado Otolaryngology and Maxillofacial Society Rocky Mountain Ear Round-up

July 23 - 24, 1998

Brown Palace Hotel

321 Seventeenth Street

Denver, CO 80202

Contact: Bob Conlon, MD or Debbie Brown,

(970) 484-8686

The Managed Care Shakeout Implications for Consumers and Providers

18th Annual Dorsey Hughes Symposium

July 23 - 25, 1998

The Vail Cascade Hotel & Club

Contact: Khanh Nguyen at HealthONE

(303) 322-3515 or email - ktnguyen@ecentral.com

MS 150 Bike Tour July 11 & 12.

Volunteer RN's, EMT's and Paramedics are needed to run the first-aid stations and mobile medical vehicles. Call Carrie Cudworth at (303) 813-6677.

JCAHO: Survey Preparation for Hospital Owned Physician Offices and Clinics

July 31, 1998

Radisson Hotel Denver South

Englewood, CO

Contact: Peggy McCreary at CHA

(303) 758-1630

12th Annual Echocardiographic Symposium on 2-D and Doppler Echocardiography - sponsored by American College of Cardiology

August 2-6, 1998

Marriot's Vail Mountain Resort

Vail, CO

Contact Registration Secretary, Extramural Programs

1-800-253-4636 ext. 695

15th Annual Santa Fe Colloquium on Cardiovascular Therapy - sponsored by American College of Cardiology

October 8 - 10, 1998

Eldorado Hotel

Santa Fe, New Mexico

Contact Registration Secretary, Extramural Programs

800-253-4636 ext. 695

Clinical Diabetes & Endocrinology

January 24-28, 1999

Snowmass Conference Center

Aspen/Snowmass, Colorado

Contact: Donna Loy

(303) 789-9682 or 1-800-421-3756

Send us your calender items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calender, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

EXECUTIVE DIRECTOR'S UPDATE



*Sandra L. Maloney,
Executive Director,
Colorado Medical Society*

I must say that recent events in the federal bureaucracy concerning health care and medical practice has stirred up renewed interest on the part of physicians. The reaction is a perfectly natural one: new threats have been made that the last vestige of medical treatment will be taken from the physician.

Then, too, there are the ongoing difficulties of the physician's dealing with managed care companies, health maintenance organizations and for-profit hospital corporations. We have a fine example right here in Denver that is leaving many physicians wondering what their next move should be, and patients in a quandary about where their medical care will be coming from. Of course, I speak of the new hospital in Denver and the further widening of the chasm between medical practice and business practice.

What I'm leading up to is the splintering of the medical practice field by such things, which leads to weakening the voice of medicine. And this is one of the matters that the CMS Annual Meeting educational programs will be dealing with. As Dr. Shanks says in his invitation to attend this September meeting, the recent CMS Planning Conference opened a lot of eyes regarding the new ethical and philosophical issues brought about by the for-profit companies that now inhabit the health care field. What CMS is trying to do is to educate its member physicians to the many and varied medical/ethical aspects and possible pitfalls of managed care contracts, to aid in

smoothing out practices and relations.

Once again, Haavi Morreim of the University of Tennessee will be participating in this meeting. She has been extremely well received in Colorado and has proved that there are increased problems as well as solutions in the ethical aspects of medical practice. She presented a very thought-provoking program in May, and Dr. Shanks has asked her to come back and expand on this information with the larger number of CMS physicians in September.

Dr. Morreim has been a good friend of Colorado medicine for some time, and it is seldom any problem to have her fit a Colorado appearance into her schedule. I, personally, also want to urge you to take advantage of this CMS member service and attend all or at least a part of the Annual Meeting. Ethics and philosophy of medicine are certainly an integral part of medical practice. The lines between the bottom line and patient advocacy are becoming more and more blurred or difficult to distinguish. Medical practice is no longer a matter of black and white; there are many indeterminate shades of gray.

Where **do** you draw the line between scientific and profit motives in medical practice? The role of the CMS has always been to help physicians define the ethical practices of medicine. That's what we are about now. We need your individual input and determination. We want to help you maintain the degree of professionalism which medical practice has always provided.

"Where do you draw the line . . ."

We don't want to act without speaking or representing the largest share of our membership. That is why these meetings are important, so that you can register your approval or disapproval and help your fellow physicians reach consensus on such policy.

I urge every one (as well as spouses) in the Colorado Medical Society to attend.

At the 1998 Interim Meeting the CMS House of Delegates passed a resolution calling for CMS meetings to be more "family friendly." Most people would agree that Steamboat Springs is one of the most family-conducive "resorts" in Colorado. The Sheraton Steamboat Springs Resort and Conference Center seems an ideal place to hold this meeting because they are sensitive to the meeting and the family needs. You are encouraged to make these few days something of a vacation for your entire family, while contributing greatly to the core purpose of this organization.



ANNUAL MEETING

W. George Shanks, MD
President-Elect
Colorado Medical Society



Steamboat Springs in September

**"I urge you to attend the
128th Annual Meeting!"**

The Colorado Medical Society **President-Elect's Planning Conference** held in Vail on the first weekend in May was regarded as a success by all who attended. The first half of the conference was devoted to **Fraud and Abuse in the Medical Sector**, which, we have been told accounts for \$20 billion that are not being used for patient care.

We, as a medical society and as the major player in the health care arena, should be concerned with this vast drain of precious health care resources. We need to work closely with the federal government to eradicate blatant fraud, but at the same time we must be ever vigilant that there is no abuse directed toward our physicians when they are delivering care to their complex and often vulnerable patients.

The implementation of the E&M (Evaluation & Management) coding guidelines has been postponed for at least another year. Hopefully, they will be modified in large part before final adoption. The guidelines as proposed substantially lower the threshold for fraud and abuse. During all of this, we have to maintain the distinction between the patient's medical record and his billing record. Interchanging these will totally destroy all semblance of confidentiality and will also fill the medical record with so much busy work that the critical elements of patient care will be easily overlooked.

The second day of the planning conference in Vail was devoted to **Managing Managed Care**. Ms. Carol O'Brien from the legal department

of the AMA presented a "model managed care contract" and discussed some of the more egregious clauses currently being submitted for signature. These "model contracts" are available from the CMS or the AMA.

Haavi Morreim, PhD, a medical ethicist from the University of Tennessee and a dynamic speaker, delivered the conference keynote address. She also participated in the panel on managed care and had some very keen observations. Her first was the distinction between a "medical decision" and a "business decision". She made it clear that since every medical decision has a price tag attached, the decision will be made by the one who controls the dollars.

What is the proper or correct role of the physician in the managed care marketplace? If we continue in our current role, the managed care company which controls the money will make the business (medical) decisions and we will lose control of the medical decisions to be made.

If we don't want to lose control of our medical practice, we will have to accept the money and assume the risk.

This is the capitated model which puts us in the classic "conflict of interest".

These are some of the issues that I want to explore more fully at the CMS Annual Meeting in Steamboat Springs September 11-13. This magazine has only the tentative program schedule. The complete program will be published in upcoming issues of **Colorado Medicine**.

Guidelines for the Diagnosis of Breast Carcinoma

Presented by
Marjie Grazi Harbrecht, MD

Friday, September 11th
2:00, 3:15, and 4:30

Upon completion of this seminar, participants will be able to:

- Demonstrate an understanding of **Copic's** PRMP Guidelines when approaching breast management issues in their practice.
- Discover ways to decrease the risk of malpractice litigation alleging delay in breast cancer diagnosis.
- Obtain feedback and network with colleagues in different specialties in order to facilitate lines of communication and develop improved methods of managing patients with breast problems.

Copic Financial Seminar Scheduled for Thursday

Presented by CMS
and
The Copic Agency
Leon B. Harrion, CLU will be conducting the session

Thursday, September 10th
2:00 - 5:00 pm

This presentation will address issues regarding: financial strategies for the ever-changing health care environment.

1998 Annual Meeting Schedule*

Sheraton Steamboat Conference Center and Resort
September 10-13, 1998

Thursday, September 10

8:00 am	CMS Office opens
9:00 am	18-hole Golf Tournament - Sheraton Course
1:00 - 2:00 pm	Finance Committee
2:00 - 5:00 pm	Copic Seminar
2:00 - 5:00 pm	Board of Directors
4:30 - 8:00 pm	Registration
6:00 - 7:30 pm	Welcome Reception
	Dinner on your own

Friday, September 11

7:00 am	CMS Office opens
7:00 am - 5:00 pm	Registration
7:00 - 7:45 am	Reference Committee Breakfast
7:00 - 7:45 am	New Delegate Orientation
7:00 - 7:45 am	Rural Physicians Forum
7:15 - 8:00 am	COMPAC Board
8:00 am - noon	Exhibits
7:45 - 8:00 am	Credentials Committee
8:00 - 8:30 am	Opening Session - HOD
8:00 - 9:30 am	<i>Alliance Breakfast</i>
8:30 - 12:15 pm	General Membership Meeting
9:30 am - noon	<i>Alliance Membership Meeting</i>
9:55 - 10:10 am	Refreshment break
12:20 - 1:45 pm	<i>COMPAC/Alliance Luncheon</i>
2:00 - 3:00 pm	Copic Risk Management
2:00 - 3:00 pm	Copic Risk Management
2:15 - 4:30 pm	Reference Committee
3:15 - 5:30 pm	Reference Committee
3:15 - 4:15 pm	Copic Risk Management
3:15 - 4:15 pm	Copic Risk Management
4:00 - 7:00 pm	Exhibits
4:30 - 5:30 pm	Copic Risk Management
5:30 - 7:00 pm	Exhibitor Reception
6:30 - 8:00 pm	Women in Medicine
6:30 - 7:30 pm	Colorado Chapter, ACP/ASIM Annual Meeting
7:00 - 9:00 pm	Gone But Not Forgotten (by invitation)

Saturday, September 12

7:00 am	CMS Office opens
7:00 - 11:00 am	Registration
7:00 - 11:00 am	Exhibits
7:30 - 8:20 am	Educational Program Breakfast
7:30 - 8:20 am	Inspirational Breakfast

Saturday, September 12 (continued)

8:30 am - noon	Educational Program
noon - 1:30 pm	AMA Forum Lunch
5:00 - 6:00 pm	Primary Care Physician Caucus
5:30 - 6:15 pm	Meet the Candidates Reception
6:15 - 7:00 pm	Inaugural
7:00 - 10:30 pm	President's Dinner/Dance
8:30 - 10:00 pm	Copic Dessert Reception

Sunday, September 13

6:30 am	Reference Committee Reports available
7:00 am	CMS Office opens
7:00 - 10:00 am	Registration
7:00 - 8:30 am	Component Caucuses
	Arapahoe
	Aurora-Adams
	Boulder
	Clear Creek Valley
	Denver
	El Paso
	Larimer/Weld
	Pueblo/Western Slope
	Eastern Plains
8:15 - 8:30 am	Credentials Committee
8:30 - noon	Closing Session HOD
9:00 - 10:00 am	Alliance Gavel Club Breakfast
noon or following HOD	Reorganizational Board

Dress for Annual Meeting

Thursday Evening	casual, black & white attire
Friday	casual
Saturday Morning	casual
Saturday Evening	Black & White Ball - Dressy business attire or tuxedo/cocktail dress optional
Sunday	casual

* NOTE

Times are subject to change. You will receive a final schedule at registration.

On **Saturday, September 12th** Colorado Medical Society Alliance (CMSA) is planning an afternoon event for the whole family. More details of the event will be published in future *Colorado Medicine* issues.



7th Annual Colorado Rural Health Conference

**June 24, 25 & 26
Sterling, Colorado**

During a time in history when major changes are being made to our county's health system's, Colorado's rural areas have responded by creating community-appropriate programs and services to meet the needs of the people they serve. Colorado's 7th Annual Conference is an opportunity for everyone interested in "enhancing health care services in Colorado" to learn about new and exciting programs and services in Colorado, and nationally as well, as innovative rural answers to health care problems.

If you have questions call 303-832-7493 or 1-800-851-6782 in Rural Colorado.

Attention Rural Physicians

CMS is offering a **Rural Physicians Forum** on Friday, September 11th 7:00 to 7:45 am. CMS would like to invite all rural physicians to the forum we will be delivering CMS Foundation and CROP updates. We 'd love to hear from you. Please join us!

NEW this year!

Rural Physicians Caucus on Sunday, September 13th 7:00 to 8:30 am. Eastern Plains doctors are encouraged to come review the reference committee report and help stratigize testimony.

Haavi Morreim, PhD, medical ethicist, to keynote Annual Meeting



E. Haavi Morreim,

E. Haavi Morreim, PhD, professor in the Department of Human Values and Ethics, College of Medicine, University of Tennessee, will keynote the 128th Annual Meeting of the CMS House of Delegates at the Sheraton Steamboat Springs Resort and Conference Center. Dr. Morreim was also the keynoter at the CMS President-elect's Planning Conference at Vail in May and was extremely well received. She is an expert on medical ethics. Her address at Steamboat Springs will be concerning the gray areas of medical practice in dealing with managed care organizations.

Prior to accepting her position with the University of Tennessee in 1984, she was at the University of Virginia School of Medicine. She was named a full professor at the University of Tennessee in 1993. Dr. Morreim is the author of numerous articles and book chapters as well as *Balancing Act: The New Medical Ethics of Medicine's New Economics* published in 1991, republished in paperback in 1995.

Dr. Morreim received her PhD in philosophy in 1980 from the University of Virginia. She is a member of the American Society for Bioethics and Humanities, the American Society of Law, Medicine & Ethics, the Hastings Center and the National Health Lawyers Association.

Dr. Morreim will be recognized in the 53rd edition of *Who's Who in America* (1999), and in the 20th edition of *Who's Who of American Women 1997-98*, forthcoming. She is a member of Phi Beta Kappa.

CMS Annual Meeting Golf Tournament

Sheraton Steamboat Golf Club

Thursday, September 10, 1998

Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____

Home Phone _____

Fax Number _____

While in Steamboat I will be staying at _____

I will be attending the meeting in the capacity of:

☐ Physician ☐ Exhibitor ☐ Spouse ☐ Other

My golf handicap is _____ or My average score is _____

Please reserve a set of ☐ Left handed ☐ Right handed clubs for me.

I will pay the \$25 rental fee on site.

If you would like to play, please return this entry form as soon as possible because space is limited.

CMS has reserved tee time, starting at 9:00 am. for only eight foursomes. Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament reservation, entry form and advance payment of \$95 must be received no later than August 21, 1998. Cancellations received after August 21, 1998 are refundable subject to ability of Sheraton Steamboat Golf Club to "resell" vacated tee time.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at 970-879-1391.

I prefer to be teamed with: _____

Mail Entry Form and Check to:

Barbara Campbell, 2251 Ash Street, Denver, CO 80207. For more information please call Barbara at 303-388-5307.

Hotel Registration

Colorado Medical Society Annual Meeting
September 10-13, 1998



Sheraton Steamboat
RESORT

Name _____

additional person(s) sharing room _____

Address _____

City/State _____ Zip _____

Phone _____

Arrival date _____ Departure date _____

Please reserve the following:

☐ Single ☐ Double ☐ Non-Smoking ☐ Smoking

Payment type - *Personal check or major credit card may be used to secure deposit. First night's deposit (room only) per unit is due in our office within ten days from the date the reservation is made.*

☐ Check ☐ Credit Card Type of Card _____

Card # _____ Exp. Date _____

Name of Cardholder _____

"I authorize Sheraton Steamboat to charge my credit card for the deposit and prepayment for accommodations listed above."

Signature _____ Date _____

Please call direct for availability of condominiums and other types of accommodations. If reservations have already been made directly with the hotel, please do not send this card. To make reservations by mail, please complete this form. To guarantee these special rates, **reservations must be received by August 12, 1998.**

Single Rate	\$110 + tax
Double Rate	\$110 + tax
Check-in Time	5:00 pm
Check-out Time	11:00 am

Children 17 and under stay for free in parent's room with existing bedding. Current sales tax and resort fees are 10.6% (subject to change). **Cancellation Policy:** Cancellations made less than 72 hours prior to arrival are subject to a one night's cancellation fee. No shows, late arrivals, and early departures will be assessed and charged for full length of entire stay as originally booked.

Call for Nominations

Colorado Medical Society Certificate of Service

Each year, Colorado Medical Society awards a physician with the prestigious Colorado Medical Society Certificate of Service, recognizing outstanding effort and devotion to the purposes of organized medicine. The award is given to an individual who displayed unusual efforts on behalf of the Colorado Medical Society, or noteworthy contributions to the practice of medicine in Colorado.

This award, given by the Colorado Medical Society House of Delegates at each year's Annual Meeting, goes to a physician named by his/her peers. You are urged to consider this award and the activities at both state and local levels, and nominate that individual whom you feel has made an outstanding contribution.

Nominations are due on or before June 30, 1998.

Please call CMS at 1-800-654-5653 or (303) 779-5455, extension 2418, to request a nomination form.

Annual Meeting Registration

1998 Annual Meeting of the Colorado Medical Society House of Delegates and the CMS Alliance
September 10-13, 1998, Sheraton Steamboat Conference Center and Resort

Name (please print) _____

Component Society _____ Name of Guest(s) _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservation deadline is August 12, 1998. Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders. (Note: To attend the President's Dinner Dance on Saturday, you must obtain your tickets before noon, Friday, September 11 at the Reservation Desk.)

As a member, you and one guest are entitled to attend the complimentary events at no charge. Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complementary Events for Member & Guest

Please indicate below which functions you will attend. Additional guests are welcome, costs are indicated below.

Thursday, September 10

	member	guest
6:00 pm Welcome Reception	<input type="checkbox"/>	<input type="checkbox"/>

Friday, September 11

		(members only)
7:00 am Rural Physicians Forum Breakfast	<input type="checkbox"/>	
8:00 am Alliance Breakfast	<input type="checkbox"/>	<input type="checkbox"/>
5:30 pm Exhibitor Reception	<input type="checkbox"/>	<input type="checkbox"/>

Saturday, September 12

			additional guests
7:30 am Educational Program Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	# _____ @ \$15/each _____
7:30 am Inspirational Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	# _____ @ \$15/each _____
8:30 am Educational Program	<input type="checkbox"/>	<input type="checkbox"/>	
Noon AMA Forum Luncheon	<input type="checkbox"/>	<input type="checkbox"/>	
7:00 pm President's Dinner Dance			
Meat dinner	<input type="checkbox"/>	<input type="checkbox"/>	# _____ @ \$50/each _____
Vegetarian Dinner	<input type="checkbox"/>	<input type="checkbox"/>	# _____ @ \$50/each _____
Vegan Dinner	<input type="checkbox"/>	<input type="checkbox"/>	# _____ @ \$50/each _____
8:30 pm Copic Dessert Reception	<input type="checkbox"/>	<input type="checkbox"/>	

Other Events:

Friday, September 11

Noon COMPAC/Alliance Luncheon	# _____ @ \$20/each _____
-------------------------------	---------------------------

Please make check payable to: **Colorado Medical Society**

Amount enclosed for additional guests and COMPC Lunch \$ _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550); phone it to us (at 303-779-5455 or 1-800-654-5653); or fax it to us (at 303-771-8657).

**Your CMS Board of Directors encourages you to
participate in this year's annual meeting.**

Gary D. VanderArk, MD, President
George W. Shanks, MD, President-elect
Robert L. Kruse, MD, Treasurer
Louise L. McDonald, MD,
Speaker of the House
Sherri J. Laubach, MD, Vice-Speaker
M. Ray Painter, MD, Past-president
Stephen G. Batuello, MD
Jack L. Berry, MD
Robert A. Brockmann, MS
John V. Buglewicz, MD
Roy E. Carlson, MD
Alfred N. Carr, MD
Donald G. Eckhoff, MD

Rod R. Holland, MD
Mary Jo Jacobs, MD
Brian L. Johnson, MD
Paul B. Jones, MD
Muryl L. Laman, MD
Nelson I. Mozia, MD
Lynn Parry, MD
Alan D. Rapp, MD
Barbara R. Reed, MD
Elaine N. Scholes, MD
Susan A. Sherman, MD
James J. Simerville, MD
Joseph R. Tyburczy Jr., MD
R. Douglas Yajko, MD

Activities Available in Steamboat Springs during the CMS 1998 Annual Meeting

This information is provided by the Sheraton Steamboat Resort and the Steamboat Springs Chamber Resort Association published in the Steamboat Springs Summertime Activities Guide.

In Steamboat, you're surrounded by two million acres of National Forest and Wilderness Areas. There are over 150 mountain lakes, two major rivers, hundreds of creeks, dozens of mineral springs and two natural hot springs. Activities abound whether you're spending two hours or an entire week in Steamboat Springs. The activities will help you plan your days while taking advantage of many of the most popular things to see and do in beautiful Yampa Valley.

Literary Sojourn Festival of Authors

Saturday, September 12

Contemporary authors share their experiences, hopes and dreams as writers. Co-sponsored by the Bud Werner Memorial Library and Off The Beaten Path Bookstore and Coffee-house. (970) 879-0240.

What to do in Steamboat Springs:

Walk, bike or skate the winding paved trail along the Yampa River Visit scenic Fish Creek Falls

Ride the Silver Bullet gondola up Mt. Werner to Thunderhead Park

Float high above mountain peaks in a hot-air balloon
1/2 and 1 hour tours \$80 to \$150 per person

Take a relaxing soak in the Strawberry Park Hot Springs
a 20 minute drive, 10 am to midnight, \$5 per person

Tour the beauty of the area on horseback,
daily 1 and 2 hour rides, \$30-35 per person

Learn the sport of fly fishing
\$50-85 per day, license and flies not included

Explore the ski mountain on a mountain bike
\$6 per hour, \$10 for 1/2 day and \$16 for full day

Enjoy a round of golf on a Robert Trent Jones II course
while taking in Steamboat's glorious climate

Most activities can be booked with Sheraton's Concierge staff in the hotel lobby, extension 1005. Prices subject to change.

President's Dinner Dance

The Black and White Ball



The President's Dinner Dance Saturday night, September 12th will be a fun-filled gala planned for you and your significant other.

Join President-elect W. George Shanks, MD, in a night of music and dance to celebrate another successful year for the medical society and usher in a new year of involvement and action by Colorado's physician community.

A multitude of music, entertainment and enjoyment await you as a sumptuous dinner is served, and you'll hear your favorite music. Dress is black tie or business (suits for men and dressy business attire or cocktail dresses for women, however, tuxedos are optional and welcome).

Dinner will be served at 7:00 p.m., and dancing will begin soon after. Plan now to join your fellow physicians and others for a night of dining and dancing you will not soon forget!

CALL FOR NOMINATIONS

1998 Wyeth-Ayerst Physician Award for Community Service

The Colorado Medical Society is pleased to announce that once again the Society will be cooperating with Wyeth-Ayerst Laboratories in presenting the 1998 Physician Award for Community Service. This is an opportunity for you, CMS members, to honor one of your fellows who has contributed in an outstanding way to his or her community. The criteria are simple, as follows:

- The recipient must be a physician licensed within Colorado.
- The recipient must be living; no posthumous awards are permitted.
- The recipient may not have received this award previously.
- The recipient has completed an outstanding record of community service which reflects well on the physician.

Each nomination made must be accompanied by a personal data sheet describing the nominee's community work. Supporting documents (testimonial letters and statements, published data, etc.) should also accompany the nomination. None of the materials will be returned.

Nominations must be received by June 30, 1998. It is very important that **all nominations and supporting material be mailed to the following address:**

**Confidential Awards Committee
Colorado Medical Society
P. O. Box 17550
Denver, CO 80217-0550**



ANTAVIRUS BULLETIN

by Richard E. Hoffman, MD, MPH, State Epidemiologist, Colorado Dept. of Public Health & Environment
Nancy Madinger, MD, Assistant Professor, Division of Infectious Diseases, University of Colorado School of Medicine

May 14, 1998

Dear Colleagues:

The death of a 17-year-old resident of Teller County, Colorado from hantavirus cardiopulmonary syndrome (HPS) and the report of cases in New Mexico (2), Kansas (2) and Arizona (1) in recent weeks has raised the concern of physicians, health care workers and the public. While there have been no other deaths from HPS in the state since 1995, this tragic case highlights the potential lethality of HPS, for which the mortality rate in North America remains at 45%. In addition, rodent monitoring stations in several southwestern states have noted increases in populations of mice that can harbor hantavirus and transmit it to humans. Given the rapidity of onset of shock and respiratory failure, early recognition of the illness is critical in reducing the risk of mortality. This letter is to inform you of the early signs and symptoms of HPS and to let you know what resources are available for diagnosis, treatment and prevention of the disease.

Clinical recognition of the hantavirus prodrome. HPS begins one to six weeks after exposure to infected rodents or their excreta, although not all patients will give a history of rodent exposure. All patients experience a prodromal phase with fever, chills and myalgias, persisting for 1 to 7 days before progression to the cardiopulmonary phase. Pain in the legs and back can be very severe in hantavirus prodrome. Many patients

also experience nausea, vomiting and diarrhea. Cough and other upper respiratory symptoms are not present at the onset of the prodromal phase but instead begin hours before the onset of the noncardiogenic pulmonary edema and cardiogenic shock.

Presumptive laboratory recognition of the hantavirus prodrome.

Because there is no way to clinically distinguish between the prodrome of HPS and that of many other viral and bacterial infections, we recommend the liberal use of the complete blood count (CBC) with differential and platelet count. A low platelet count (<150,000 in 98% of cases; <130,000 in 92%) is the only CBC abnormality consistently seen during the prodromal phase. All HPS cases eventually have platelets <100,000. Other nonspecific lab results suggestive of prodromal HPS include elevated LDH, elevated AST, and reduced serum bicarbonate. Patients with symptoms consistent with early HPS but with platelet counts of >150,000 should be advised to return to your clinic in 24 hours for re-evaluation.

Presumptive clinical and laboratory recognition of the HPS syndrome. The transition from hantavirus prodrome to HPS/respiratory failure occurs 4 to 12 hours after the onset of cough and shortness of breath. With the onset of pulmonary edema, the CBC now shows thrombocytopenia, elevated hematocrit, leukocytosis with circulating myelocytes and promyelocytes, and immunoblasts, recognized as large atypical lymphocytes with deep blue cytoplasm.

Acidosis (lactic), mild coagulopathy, elevated LDH and hepatic enzymes, and reduced serum albumin are usually seen. Serum creatinine is usually not elevated unless dehydration due to vomiting and diarrhea is severe. Hypotension in HPS is due to cardiogenic shock with low cardiac output and normal or elevated peripheral vascular resistance. Patients presenting with bilateral alveolar-interstitial infiltrates and hypotension and plasma lactate greater than 4 meg/L (note: your laboratory may use different units) have a high risk of mortality.

Source of more general information on HPS. Clinicians with Internet access can find out more about the clinical and laboratory recognition of HPS at the University of New Mexico Department of Pathology's website at the following URL: <http://thor.unm.edu/Hanta/Website1.htm#recog>. The Centers for Disease Control and Prevention (CDC) also maintains a comprehensive educational website at www.cdc.gov/ncidod/diseases/hanta/hps/, and similar information can be received via the CDC fax retrieval service at (888) 233-3228.

Immediate consultation and referral. Patients with suspected HPS (thrombocytopenia and compatible clinical picture) should be transported to a critical-care unit as early as possible, because the fluid management should be guided by Swan-Ganz catheter data, hypotension must be treated with inotropes (initiate treatment with dobutamine), and oxygenation may be difficult even with mechanical ventilation.

(Continued)

All patients with suspected HPS should be under respiratory isolation until the diagnosis of HPS is confirmed by serology. No approved antiviral treatment is available for HPS.

For consultation on suspected cases of HPS, physicians may call the Infectious Disease Clinic at University Hospital at 303-372-8683 during regular working hours or 303-372-0000 after hours, weekends, and holidays. When calling the later number, ask the hospital operator to page the Infectious Disease Clinic doctor on call. Consultation is also available from the Colorado Department of Public Health and Environment (CDPHE). During regular business hours, the number is 303-692-2700 and after hours the number is 303-370-9395.

Rapid diagnostic testing. Diagnostic testing for hantavirus infections is available at the state health department virology laboratory. The typical initial test is an IgM antibody assay that can distinguish acute from past infection with the Sin Nombre virus. The IgM antibody assay test for Sin Nombre virus is not

available through private referral laboratories. Blood for serologic testing should be drawn into a red top tube and held at refrigerator temperature. Either whole blood or serum may be submitted. Specimens should be sent on cold pack via same-day or next-day delivery.

Results are available within 48 hours after receipt by the laboratory. Inquiries about laboratory testing can be made to Larry Briggs, Supervisor, Virology Laboratory at **303-692-3482 or 303-692-3485**. A submission form must accompany the sample and should include the patient's name, requested test, and name, address, and telephone/fax number of the submitting physician or hospital (where the results should be sent). Submission forms will be provided by the state lab, but any paper form that records the above information may be used.

For general questions about HPS. If you or your patients have general questions about the signs and symptoms of HPS, what to do after exposure to rodents, prevention of hantavirus infections, or other issues not related to a specific case

of suspected HPS, the CDPHE's Division of Disease Control and Environmental Epidemiology has a hotline recording that can be accessed 24 hours/day-the number is 303-692-2667. General questions on hantavirus for CDPHE should be directed to 303-692-2700, 8:30 am to 5:00 pm. Other information about prevention of hantavirus infections is available at the CDC website www.cdc.gov/ncidod/diseases/hanta/hps.

Be aware that HPS can occur anywhere in the state, not just the southwestern corner where it was first recognized in 1993. Infected rodents have been reported from all areas of Colorado. This year's wet winter and spring may lead to more cases of hantavirus infection among Colorado residents. Prevention of further deaths will depend upon the ability of clinicians like yourself to recognize the disease early in its course. Please take time to familiarize yourself with the information presented herein and to access other sources of information if you have further questions.

Highlights of the Colorado Medical Society Board of Directors Meeting

Held at the Sonnenalp Resort, Vail, Colorado, May 1, 1998

- A. CMSA: Ms. Donna Foss presented the report in the absence of Co-Presidents Leslie Nathan and Sue Foerster. Ms. Foss stated that the Co-Presidents, along with several other Alliance members, will be attending the American Medical Association Alliance meeting in June.
- B. AMA Delegation: Dr. Ray Painter stated that the AMA has been diligently working on making changes in the new Evaluation and Management (E&M) Documentation Guidelines. Dr. Painter attended the recent fly-in meeting conducted by the AMA regarding the E&M Documentation Guidelines. The implementation date for these documentation guidelines has once again been delayed.
- C. Medical Executives: Ms. Judy Ladd thanked Copic for hosting the annual Medical Executives Retreat at the Sonnenalp. She stated that an excellent program was presented by the Copic staff, and that Ms. Lorraine Koehn was excellent in presenting legislative information. The new chair of the Medical Executives is Ms. Donna Foss.
- D. Dr. Terry Sullivan presented an update on the Colorado Rural Outreach Program (CROP). After his presentation, the decision was made to add CROP to the CMS budget, and to hire a full time staff person for the CMS Foundation Board.

The next CMS Board meeting will be held on July 31, 1998 at the Colorado Medical Society Office.



PRESIDENT ELECT'S PLANNING CONFERENCE

Sonnenalp Resort & Conference Center • May 1-2, 1998

Varying aspects of health care fraud and abuse were presented by Joy Grinstead (OIG, HCFA), Special Agent Gary Johnson (FBI), Margaret Cary, MD (Regional Director, Health & Human Services), and Robert N. Spencer, Esq., (Montgomery, Little & McGrew, PC).

Ms. Grinstead said that the cost of health care approaches \$1 trillion per year, and fraud and abuse is costing approximately 20% of that, or \$80 to \$100 billion per year.

Fraud, she said, is the commission of an act, knowing that the act is false or misleading and committed for the person's own good. For example, billing for services or supplies that were not actually provided.

Abuse is defined as acts inconsistent with sound business or medical practices which result in unnec-

essary cost to the insurance company or which are medically unnecessary.

Mr. Spencer addressed the aspects of "honest mistakes" in billing and the various standards of culpability in civil penalty statutes.

Dr. Margaret Cary gave some reassuring news, in that physician fraud and abuse accounts for only 1 to 2% of the total. However, she

pointed out that the concern over the matter is legitimate when you translate the total cost into daily loss of health care resources: approximately \$55 million per day.

FBI Special Agent Gary Johnson, in charge of investigation of "white collar" crime in Colorado and Wyoming, said that health care fraud and abuse is a very appealing field to the criminal element. He said that dealers are leaving the hard drug trade and getting into health care because it is such a clean business:



The panel (l to r) are Joy Grinstead, HCFA, FBI Special Agent Gary Johnson and HHS Region VIII Director, Maggi Cary, MD. They participated in the discussion about Fraud and Abuse in the health care arena.

no violence and sentences are so light (if you are caught) that few people ever spend any time in jail for a conviction.

Johnson added that one element showing up in Colorado is the so-called Russian "Mafia." He said they were committing fraudulent practices within their own closed community and getting away with them because no one talked about it.

As had been shown by the presentations, fraud and abuse is a major government problem, and (l to r) Drs. Jack Cletcher and Jack Berry were quick to tackle some of these problems with U. S. Representative Scott McInnis (R-3rd District) who attended the presentation. McInnis attended the morning presentation as an observer, showing particular concern over the E & M coding.

The second day of the conference was devoted chiefly to "Managing Managed Care", and Haavi Morreim, Ph.D., tackled the subject head-on, putting an entirely new slant on the subject. She told conferees the managed care system needs to get rid of the standard of "medically necessary" in judging what conditions to treat. Dr. Morreim pointed out that very little of health care is medically necessary. Very little of orthopedic medicine is necessary. It is "quality of life." With the exception of suicide, nothing in mental health is "medically necessary;" it is all quality of life. Dermatology is all quality of life, except for skin cancer. Most of rheumatology is quality of life. In fact, most of all practice of medicine is quality of life and not medically necessary, and most of all treatment decisions are value choices. Variation of health care coverage offered by insurance and managed care is totally legitimate, as long as the variations are all up front. The notion of medical necessity just doesn't apply to much, if not most, of medical care. Health care plans, she said, have a perfect right to exclude certain aspects of treatment or care as long as the patient contracts are fair and just and

non-arbitrary. Medical necessity, she said, "is a 'moosh' word; it doesn't mean a darned thing and is virtually unenforceable."

From this conference came a fairly clear outline of what would follow at the 1998 Annual Meeting (see Dr. Shanks' article concerning the "1998 Annual Meeting").

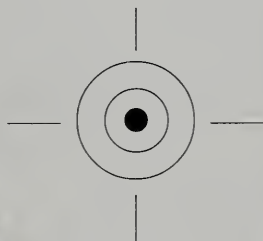
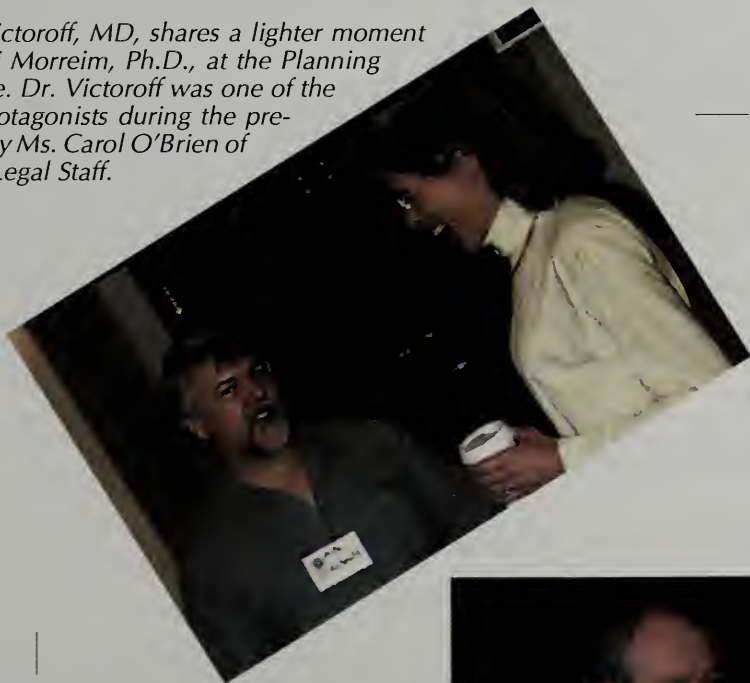


Bruce Blehart, JD, of the AMA Legal Department, talks to Rep. McInnis



Dr. Jack Cletcher of Longmont (l) and Dr. Jack Berry of Wray, Colorado, are intense in their discussion with U. S. Dist. 3 Rep. Scott McInnis. Dr. Cletcher was attempting to make a point to Rep. McInnis concerning the E & M coding. They were speaking outside the conference rooms at the Sonnenalp Resort during the President-Elect's Planning Conference.

Michael Victoroff, MD, shares a lighter moment with Haavi Morreim, Ph.D., at the Planning Conference. Dr. Victoroff was one of the primary protagonists during the presentation by Ms. Carol O'Brien of the AMA Legal Staff.



Ms. Carol O'Brien, JD, of the AMA Legal Offices was a principal speaker on Sunday, May 2nd, when the Conference addressed "Managing Managed Care." Ms. O'Brien's presentation dealt with the ideal physician-insurance company contract and some of the things for which physicians should be on the lookout. Ms. O'Brien was challenged a number of times by physician (insurance company) medical directors in the audience.



A note about Robert Sawyer, MD (r), who was not featured in the program but who observed an important milestone on May 2nd: it was his birthday.

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If you don't grab the life preserver, no one can pull you to safety. We've thrown you the preserver, and we'll pull you to safety, but you'll have to help. See the Executive Director's Update, page 213, and "The Hassle Factor Project".



Look for this AM 98 identifier on the articles associated with the CMS 1998 Annual Meeting

AM 98

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COLORADO MEDICINE

July, 1998

Volume 95, Number 7



Whether we are described as a "club cruiser" or a hard-shell buccaneer, the Colorado Medical Society sails to the rescue of its members regularly and continuously. See the "**Executive Director's Update**" and page 215 re: "**The Hassle Factor**".

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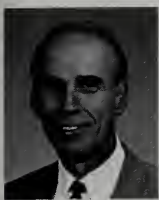


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PRESIDENT'S LETTER



Gary D. VanderArk, MD
President, 1997-1998

I have just had a profound, life changing experience. Phyllis, my wife, and I recently returned from a two and a half week trip to Israel. Our trip was called Israel in Depth and we spent 17 very hectic 16-hour days exploring Biblical history in the land where God has especially been revealed.

While there, I learned a lot about sheep and goats. In many ways, sheep and goats are dumb animals. They are not herded like cattle but rather follow their shepherd who is always looking for green pastures or water. I was amazed to discover that the shepherds were usually kids 10 to 16 years of age and more often than not, girls. The shepherd has to know where she's leading because there is rarely enough food for more than a few minutes and there always has to be a known source of water. The sheep and goats become so attached to their shepherd that when their shepherd gets married or joins the Army, they have to be slaughtered because they won't follow anyone else. I have a new appreciation for the 23rd Psalm; "The Lord is my Shepherd".

There are two features that make goats a lot different than sheep. In the first place, sheep nibble the grass off just above the ground whereas goats pull the whole thing out by its roots. That's a bad difference in a land that is very rocky and arid. In the second place, goats tend to wander a lot more than sheep which means that their shepherd has to spend a lot of time yelling at them and throwing things at them to get them to follow.

What in the world does all of this have to do with medicine? You are probably thinking "Oh no, this is where he is going to compare us to sheep (or even worse, goats)." Well, I do think there is an analogy here, or in Biblical terms, maybe even a parable. My analogy, however, has to do with the shepherd. We need to be shepherds!

Health care at the end of the twentieth century is crying out for shepherds. We need physicians who can provide the leadership that shepherds provide. We, not 35 year-old MBA's must show the way. We must be the good shepherds.

Shepherds have to be caring, have organizational skills and show wisdom. That's exactly the kind of leadership we must demonstrate.

We must care! As physicians, we must have passion, Remember for a minute why you went into medicine to begin with. We must insist that good medical practice dictates policies and procedures. Policies and procedures should never determine medical practice. Love what you do and people will follow your direction. Having a sense of purpose will help us make sense of our world. Your passion will generate direction. You must inspire people and turn malaise into hope.

Good shepherds have organizational ability. We need to be leaders that generate activity. Sheep are always moving; shepherds need to provide direction. Medicine is going through an identity crisis. Managed care would redefine what we do but physicians must set the standards. Shepherds even yell and throw

Change is inevitable; let's make it progress.

stones which certainly seems similar to my style of leadership. Just kidding... but leaders do need to keep their organizations moving forward. Change is inevitable; let's make it progress.

Finally, today's medical leader needs wisdom. As Solomon has said "Wisdom will save you from the ways of wicked men." As the shepherd always knows how to meet the needs of the sheep, so we too need to have answers for today's health care questions. I was amazed to see what happened when two or more flocks arrived at a watering hole at the same time. The shepherds were able to cooperate and always showed lots of patience. I think that's the kind of wisdom medical leaders need for today. We must be able to cooperate and collaborate. We will have to be able to integrate our practices into the emerging picture that is our health care system. We must be able to collaborate among ourselves and with those in other health professions as well as with politicians and business leaders. We must forge the alliances of the future.

Health care is crying out for leadership. We can be the leaders of the future. We can be good shepherds—just watch where you step!

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CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax®
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

Revised E & M Documentation Guidelines - AMA House of Delegates asks HCFA to adjust its course

Last month at their annual meeting the American Medical Association (AMA) presented delegates with a copy of the proposed framework for the revised E & M Documentation Guidelines. These guidelines were drafted after leaders of organized medicine convened in Chicago in April to discuss physician concerns over the 1997 revisions. The guidelines were simplified and incorporated many of the comments the AMA received from physicians. However, the overall "framework" was unchanged, and would require documentation "by the numbers" with the familiar bullets/elements.

It was apparently this fact that caused delegates to vote to oppose the new framework that the Health Care Financing Administration (HCFA) and the CPT Editorial Panel had hoped would be acceptable to physicians. Instead the house

(continued on page 2)

18th Annual Dorsey-Hughes Symposium "The Managed Care Shakeout"

Many local as well as national health care experts will discuss the challenges facing the managed care industry. Local dignitaries include Jeff Dorsey of Columbia/HCA, Gary Susnara of Centura Health Corporation, Jeff Selberg of Exempla Healthcare and Patrica Gabow, MD of Denver Health Medical Center.

Held July 23-25, 1998 at Vail Cascade Hotel & Club in Vail, CO. Please contact Khanh Nguyen, grand administrator at (303) 355-9771 x313 for further information or to register for this nationally-acclaimed health care policy symposium.

1998 Medicare Workshops

The Medicare carrier, Blue Cross and Blue Shield of North Dakota, will be conducting Part B workshops throughout the state beginning in July. This year the workshops will be broken down into two separate sessions. The morning session will cover basic billing information and the afternoon session will cover information on the Medicare provisions of the 1997 Balanced Budget Act. It is not necessary to attend both sessions. Attendees will receive a copy of the new "Medicare Basic Billing Manual".

To register, you must return the preprinted enrollment form approximately 10 days prior to the session you wish to attend. There is a charge of \$45 per person, per session. If you did not receive the workshop form in the mail, call 831-1221 to obtain one.

Following is the schedule (please check your enrollment form for the complete location), all morning sessions are from 8:30 to 11:30 AM and all afternoon sessions are from 1:00 until 4:00 PM.

<u>Date</u>	<u>Place</u>
Thursday, 7/30	Pueblo, Holiday Inn
Friday, 7/31	Colorado Springs, Double Tree
Wednesday, 8/5	Denver, Holiday Inn Northglenn
Thursday, 8/6	Denver, Holiday Inn Northglenn
Wednesday, 8/12	Greeley, Ramada Inn
Thursday, 8/13	Greeley, Ramada Inn
Wednesday, 9/2	Denver West Sheraton
Thursday, 9/3	Denver West Sheraton
Thursday, 9/17	Glenwood Springs, Hotel Colorado
Wednesday, 9/23	Grand Junction, Holiday Inn
Friday, 9/25	Durango, Double Tree

CMS Med Fax

Revised E & M Documentation Guidelines - AMA House of Delegates asks HCFA to adjust its course

(continued from page 1)

voted to "oppose any documentation system that requires quantitative formulas or assigns numeric values to elements in the medical record to qualify as clinically appropriate medical record-keeping."

The resolution that was adopted does commit the AMA to continued cooperation with HCFA and the CPT Editorial Panel in developing simplified documentation guidelines. At this point, the AMA's position is that future guidelines should be based on what a physician peer reviewer would need to assess the level of service based on the medical record, other related information and the appropriate CPT guidelines.

HCFA's response to the House of Delegates' action was not unanticipated. In a recent press release Robert Berenson, MD, Director of HCFA's Center for Health Plans and Providers, indicated that they must move forward to refine and implement a set of documentation guidelines. He felt that although some of the provisions of the resolution appear constructive, overall the resolution would essentially nullify the guidelines without providing any viable alternative.

The CPT Editorial Panel will be considering the E & M guidelines at their meeting in August. The AMA is asking that physicians who want to review and comment on the guideline changes do so prior to this meeting. **Comments must be submitted to the AMA by July 24, 1998.** You can contact Marilyn Rissmiller in the CMS Health Care Financing Department on 779-5455 or 1-800-654-5653, ext. 2428 if you would like a copy of the latest revisions.

Sixth Annual Medical Informatics Fair

The Denver Medical Library is pleased to announce the sixth annual Rocky Mountain Regional Informatics Fair. The theme of this year's fair is "Computers in Medicine: Tools at the Point of Care." The fair will take place Friday & Saturday, September 25 & 26, 1998 with an "Evaluating Computer Solutions for the Medical Office" workshop on Thursday night September 24. We will be located in the Russell Pavilion at Saint Joseph Hospital, 1835 Franklin Street, Denver.

The fair is a forum for discussion of issues and developments in medical computing which impact practicing physicians. Our goal is to inform the medical community about the ongoing revolution in information technology, in areas including, but not limited to, knowledge access, medical records, data interchange, and clinical and management decision support. This year's fair will feature a panel discussion on hand-held devices, as well as presentations on Year 2000 issues, biometrics, Simulations, Clinical Computing, Telemedicine, National Healthcare EDI issues, and more. For more information call The Denver Medical Library at (303) 839-6670.

Following the fair CMS Medical Informatics Committee is holding a CME series. The program is designed to allow physicians hands-on training and will include a ticket to the Informatics Fair and five hands on courses as follows:

Kaiser Training Center	Saturday, October 10
Kaiser Westminster Clinic	Saturday, October 17
Dennison Library	Saturday, October 24
Medical Group Management Association (MGMA)	Saturday, November 7
Center for Human Simulation	Saturday, November 14

For more information contact Suzi Shevell: 930-0407; 1-800-654-5633, ext. 2407 or Lorraine Heth: 930-0409; 1-800-654-5633, ext. 2409.

Columbine Medical Group physicians Read This Notice!

The Colorado Medical Society has just been faxed a page from the CMG Update 2nd Quarter 1998, Volume 4, Issue 3. On the bottom of the first column of page 347 is a notice of specialty fee-for-service reimbursement changes. The office that faxed the article to us stated that they have not received any other notification. Our concern is that physicians may not read the article and therefore, not be aware of the changes to their reimbursement. Because we do not have permission to reprint the notice, we encourage you as a Columbine Medical Group physician to read the notice.

The notice reads:

The CMG Contract Finance Committee has made the following changes to specialty fee-for-service reimbursement: (1) effective April 1, 1998, the withhold increased to 30 percent; (2) effective May 1, 1998, the withhold increased to 35 percent; and (3) the conversion factor for CPT codes 10040 to 69979 will be reduced 5 percent to \$68 per unit.

Medicaid Fiscal Agent Transition Delayed

The Colorado Medical Society has just learned that the Medicaid Fiscal Agent Transition rescheduled for October 1, 1998 has again been delayed. The new transition date has not been announced. It is anticipated that a bulletin from the current fiscal agent, Blue Cross Blue Shield of Colorado, announcing the new date will be sent out in July.

AM 98

September 11 - 13, 1998

Steamboat Springs

Physician Appointment, a 50 Year Tradition Resumed

Jack T. Dillon, MD director of emergency resources for the Penrose St. Francis Hospital, was unanimously chosen to fill a vacancy on the El Paso County board of health. The board oversees policy and finances for the El Paso County Department of Health. Dr. Dillon will serve until December 31, 2001 when his predecessor Robert LeBree's term was to expire.



CALL FOR NOMINATIONS

The Colorado Medical Society will be holding elections at the upcoming Annual Meeting in September. CMS requests nominations for the following:

- American Medical Association (AMA) Delegates
- AMA Alternate Delegate
- Vice-Speaker of the House of Delegates
- President-elect

Dr. Richert Quinn is running for re-election as AMA Delegate.

Dr. Robert McCartney is running for re-election as AMA Alternate Delegate.

Dr. Sherri Laubach is running for re-election as Vice-Speaker of the CMS House of Delegates.

If you are interested in running for any of the above offices, please submit your name and a current resume' to the CMS Executive Office, PO Box 17550, Denver, CO 80217-0550. If you have any questions, please contact either Sandra Maloney or Debra Jones at 303-779-5455 or 1-800-654-5653.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

**Colorado Otolaryngology and Maxillofacial Society
Rocky Mountain Ear Round-up**

July 23-24, 1998

Brown Palace Hotel

321 Seventeenth Street

Denver, Colorado

Contact: Bob Conlon, MD or Debbie Brown
(970) 484-8686

**JCAHO: Survey Preparation for Hospital Owned
Physician Offices and Clinics**

July 31, 1998

Radisson Hotel Denver South

Englewood, Colorado

Contact: Peggy McCreary at CHA
(303) 758-1630

**12th Annual Echocardiographic Symposium on 2-D
and Doppler Echocardiography - sponsored by
American College of Cardiology**

August 2-6, 1998

Marriott's Vail Mountain Resort

Vail, Colorado

Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

**Human Resources Management: Staff Education,
Training and Competency Appraisal for Hospitals**

August 6-7, 1998

Executive Tower Hotel

Denver, Colorado

Contact: Peggy McCreary at CHA
(303) 758-1630

Menopause: A Rapidly Changing Scene

September 19, 1998

Inverness Hotel & Golf Club

Englewood, Colorado

Contact: Joanne Sherman at HealthONE CME
(303) 360-3320

Fall Clinics of Montrose, Colorado

September 25-26, 1998

Montrose Memorial Hospital

Montrose, Colorado

Contact: Kathy Holman
(970) 240-7397

**15th Annual Santa Fe Colloquium on
Cardiovascular Therapy - sponsored by American
College of Cardiology**

October 8-10, 1998

Eldorado Hotel

Santa Fe, New Mexico

Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

**The Association of Managed Healthcare
Organizations 1998 Fall Forum**

October 11-13, 1998

J.W. Marriott Hotel

Washington, DC

Contact: Elisa Ricciuto
1-800-642-2515 or www.amho.org

Clinical Diabetes & Endocrinology

January 24-28, 1999

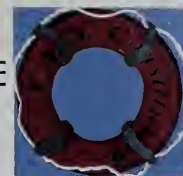
Snowmass Conference Center

Aspen/Snowmass, Colorado

Contact: Donna Loy
(303) 789-9682 or 1-800-421-3756

Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.



Sandra L. Maloney,
Executive Director,
Colorado Medical Society

I have received a number of messages in recent months about managed care, HMOs and the increasing trend in the "not covered" aspects of medicine. Doctors are asking what can be done about the large number of medicines prescribed for their patients that, upon entering a claim for payment or reimbursement, the insurance carriers are denying.

Many of the physician comments are directed particularly at their fellow physicians who serve as "medical directors" for the insurance companies. Doctors say they are being told that this particular drug is not covered and (in similar terms) "get used to the fact: it won't be covered in the future." What are a treating physician's choices: quit the panel or swallow hard and go on with the practice, sans using "best-information" treatment protocols.

How does this sort of breach occur? What has literally turned doctor against doctor in treatment approaches and some of the most basic medical algorithms? Why has the treating doctor had to go back to the HMO medical director so many times to get authorization for what seemed to be the most routine prescriptive procedure? Must be money.

These physician queries to CMS are (and rightly so) always followed by "What's CMS doing about this?" Well, here's what we have been about, and are not about to quit:

- Since 1995 CMS has had a CMS/Colorado HMO Association (CHMOA) Joint Committee which has functioned very effectively and accomplished a number of things.

1. Negotiated compromise legislation on physician gag clauses in managed care/HMO contracts.
2. Developed a system of handling individual physician grievances.
3. Established "Continuity of Care" guidelines.
4. Held preliminary discussions on a "model" managed care contract.

Currently, CMS is conducting a Formulary Task Force to standardize the format of the formularies. The Managed Care Task Force is also attempting to create a "minimal" formulary. We hear your problems and complaints and we are trying to meet these needs through the bargaining voice of the organization. I have to tell you, though, it takes a few miles to make the ship, *CMS Constitution*, change course. We are no longer in the *Cruiser* class we're more like a *Frigate* and are trying hard to stay out of the *Destroyer* class. We want to be a vessel of serious intent, and certainly not looked upon as a "pleasure craft" out for a Sunday sail.

However we're seen, our intentions are serious and we have been at the negotiating table for almost four years now. We're still sailing full steam. I have to salute the CHMOA members for their contributions and their willingness to be at the helm with us. While I'm at it, I want to tip my seaman's cap to Dr. Joel Karlin for his continuous and untiring efforts in these channels; he has steadfastly refused to abandon ship in the face of many a stormy session since creating this Joint Committee while Captain of *CMS*.

Ahoy There!

If you've some idea that this is all CMS' job, belay that! I'll have you at the mast in no time. Here's what you have to do:

1. Go directly to page 215 of this issue of *Colorado Medicine* and follow the instructions concerning the CMS "Hassle Factor Project."
2. See to it that your office personnel, including Physician Assistants, Nurse Practitioners and Med-Techs are each familiar with this program and that they follow through with letting CMS know the details of your office's problems.

It's all right there in front of you; just do it! And CMS will do its part. But we have to have the information from you. We're getting a fair return from our earlier publication of this proposal, but we need more, and for every one of you out there who says anything about this sort of problem to CMS, we know you haven't been reading our manual thoroughly.

So, Avast! Let's work with the Captain 'n crew of *CMS Constitution* and hoist sail. We've scanned the map and now we must stay the course. All hands on deck! Let's pull together.

Don't let 'em **hassle** you Matey.

HIV/AIDS Prevention, Early Intervention and Health Promotion:



A Self-Study Module for Rural Health Care Providers

On the Internet: <http://www.uchsc.edu/sm/aids>

(Providers unable to access the Internet may call toll-free:
1-888-861-8536 to request a printed edition.)

The self-study module prepares health care providers to:


- educate their patients to identify and reduce their risk for HIV infection
- identify HIV-infected patients as early as possible to maximize health outcomes
- encourage HIV-infected patients to employ strategies to maintain active, symptom-free lives.

Continuing Education Activity

- Free of charge
- CME and CEUs available for physicians, physician assistants, and nurses



Mountain-Plains Regional
AIDS Education and Training Center

 University of Colorado Health Sciences Center

*This project is funded by the Health Resources and Services Administration,
Special Projects of National Significance Cooperative Agreement BRU 900108.*

Colorado Medical Society Hassle Factor Project Proposal



The goal of the project is to gather specific information regarding a wide variety of problems which physicians' offices are having with third party payers. As a result of information submitted to the CMS office, staff would assist the physician's office to resolve the problems.

The following steps would be taken:

- CMS staff would contact physician's office for details
- Initial complaint information would be added to a computer data base for tracking purposes
- CMS staff would contact the health plan to address the problem
- Possibly meet with the health plan if needed
- Complaint results would be added to the computer data base at CMS

The success of such a project will be dependent upon the willingness of the physician and his/her office staff to submit problem information to the CMS. This project can identify the source of various problems and will allow Colorado Medical Society to take the appropriate action.

Some of the actions taken may include:

- Regular meeting with various health plans to discuss system problems identified, as well as possible streamlining of claims processing;
- Discussion with physician's office staff when claims filing errors or other office deficiencies are identified;
- Seek opinions from CMS Managed Care Task Force and/or the CMS/Colorado HMO Association Joint Committee, depending upon the issue;
- Seek the opinion of the CMS consultant, depending upon the issue;
- Development of a bimonthly newsletter for physicians' offices, summarizing problems and their status. This would also give information on how to avoid such problems in the future.
- Semi-annual meetings with physician office staff in each staffed component society;
- Meetings with the Colorado Division of Insurance when appropriate; and
- Annual quantitative analysis based on data received.

Practice office managers: Please complete the form on the following page and return it to CMS.

COLORADO MEDICAL SOCIETY
P.O. Box 17550, Denver, Co. 80217-0550
Phone: (303) 779-5455 or 1-800-654-5653 FAX; (303) 771-8657
HASSLE FACTOR MAILING LIST

In an effort to create a mailing list of all office managers for Colorado Medical Society (CMS) member physicians, we are asking you to fill out the following information. This information will allow CMS to send newsletters and communicate directly with the office manager for dissemination to appropriate office staff.

Please mail or fax this form to Edie Register at the address or fax number listed above.

Practice Name: _____ Specialty _____

Practice Address: _____

Practice Phone Number: _____ Fax Number _____

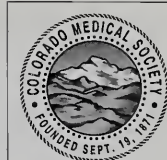
E-Mail Address: _____

Office Manager Name: _____

Office Manager Address: _____
(if different than practice) _____

Names of Physicians Within this Practice:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



Richert E. Quinn, MD
Senior CMS delegate to the AMA

The AMA House met in early June in an atmosphere of anticipation concerning the report of an ad hoc committee chaired by Colorado delegate Mark Levine, M.D. The committee dealt with matters related to the Sunbeam debacle that has dominated association affairs for the past several months. The committee found that blame for the incident should lay with AMA staff who "either ignored or failed to recognize that the Sunbeam contract...was clearly and directly contrary to AMA policy." They largely exonerated the Board of Directors regarding the Sunbeam affair, but did make some recommendations regarding Board roles in the future. The committee strongly expressed its displeasure with the Board's current modis operandi, which they viewed as being unduly focused on advocacy and ambassadorship roles and not focused enough on their fiduciary responsibility to the AMA. Ultimately, after much debate, the House voted unanimously to accept the report. Another ad hoc committee is scheduled to make a report at the interim meeting in December specifically addressing issues of structure, governance, and operations.

The race for the President-elect slot was hotly contested between Dr. Thomas Reardon, the current Chair of the AMA Board of Trustees, and Dr. Ray Scalettar, a past Board member who was challenging on the basis of member disgruntlement about the Sunbeam affair. Dr. Reardon prevailed, but the dissenting vote was large enough to send a clear message to AMA leadership about members' unhappiness over the en-

tire Sunbeam affair.

The E & M guideline issue was debated extensively. The House ultimately passed a resolution protesting the use of "bullet" points and counting of care elements to determine the appropriate level of coding. This resolution and policy change runs counter to current leadership strategy, which involved cooperation with HCFA in the development of quantitative standards. Leadership fears a lack of physician input and standards which are developed by HCFA from a "black box." Nonetheless, House members voted against the continuation of such a posture and for elimination of these types of E & M guidelines. The House also recommended that the AMA should pursue congressional action to enact the "knowing and willful" standard of proof as it applies to civil penalties relating to any coding and billing errors; opposed the use of the confidential patient medical record as an accounting document; and, also recommended that no penalties be assigned to physicians for one level of disagreement a E & M coding. Several other recommendations were built into this very strongly worded resolution. The tone of the House's action is such that some members felt it would aid the AMA with regard to its ailing membership, in that such a strong pro-physician, anti-government position had been taken.

In another anti-HCFA declaration, the AMA expressed vehement opposition to the government's proposed MEDICARE user's fees. The House even directed the AMA to request a congressional investigation

"Colorado continues to shine at these meetings."

(continued)

AMA UPDATE

of HCFA practices and administrative excesses, with particular attention to its abuse of patients, physicians, and other health professionals.

One of the more controversial issues discussed at the meeting had to do with a report from the Council on Ethical and Judicial Affairs that opposed the sale of non-prescription, health-related goods from physician offices for profit. After extensive debate, the House referred the report to the council for further consideration. The sale of skin care products, vitamin and nutritional packages, and even orthopedic splints are examples of the kinds of products under debate. The issue is whether or not sale of such items at significant profit levels represents an exploitation of pa-

tients' vulnerabilities in the physician/patient relationship.

In another very strong pro-physician statement, the House launched a collective negotiation strategy for physicians although they did reject any trade union affiliation or strike actions as possible strategies to be used in collective representation of physicians.

There were a number of other important subjects under consideration including the growth of the American Medical Accreditation (AMAP) program and its marketing efforts in the various states, and continued support for strong anti-smoking activities in the face of the demise of the Senate tobacco control bill.

Colorado continues to shine at these meetings. As mentioned, Dr. Levine chaired the most important

committee of the current year. Your author, Dr. Quinn, was re-elected to the Council on Constitution and By-laws. Dr. Joel Karlin is the candidate for the AMA Board of Trustees in the 1999 election cycle. The newer alternate delegates, Doctors Barbara Reed, Jeremy Lazarus, and Steve Thorson, have already made names for themselves in the AMA House. We plan to continue representation on behalf of Colorado physicians with much enthusiasm. We are, however, dismayed at the low level of AMA membership among our CMS members, which is along the lines that the AMA has experienced nationally. We will continue to push hard for Colorado physicians to join and beseech the support of those of you who don't currently back the AMA with your financial assets.

Doctor:

- **Does the managed care "bottom line" prevent physicians from remaining true "patient advocates?"**
- **In questions of business versus patient needs, nothing is simply black or white; how are the "shades of gray" handled by managed care?**
- **Is it possible for patient advocacy, in the traditional medical sense, to coexist with managed care needs and/or requirements?**
- **How must "traditional medicine" change to fit or interface with managed care?**

These and other questions about managing managed care will be asked and, hopefully, answered at the Colorado Medical Society Annual Meeting.

Be there! Be a part of the solution and get answers for your practice.

AM 98

Steamboat Springs, Colorado • September 11-13, 1998.

SPECIAL Poppin' Pills, Ignoring Ills



Reprint from the Boulder, Colorado Daily Camera, May 9, 1998, "The Link" by Clay Evans

Exhibit A: The young man is bright, almost frighteningly so. Driving, lightning-blue eyes. Home for the holidays recently, he talked about when we first met a few years ago; When he was on medication for manic-depression, or bipolar illness.

"I just took the pills because they said it would make me better, and I guess it helped," he said. "Once I moved out of my house and stopped taking the meds, I felt better. A lot of my problem was just my environment."

He still is bipolar, but between his vigilant girlfriend, his devoted therapist, and his own awareness of his disease, he now functions well without pills. He's creative. Intense. Brilliant. He'd like to live out his life without ever relying on meds for mental illness again.

Exhibit B: American doctors prescribed the anti-depressant Prozac to twice as many 6- to 12- year-olds in 1996 as 1995 and have reported prescribing the drug to kids as young as 3.

Never mind that there is virtually no research that shows such drugs are effective or safe for children. Nobody has any real idea how Prozac might affect the developing brain of a child, though plenty of therapists are quick to proclaim that millions of kids are depressed.

Among possible symptoms of childhood depression, they say, are: Crying, fighting, laziness, withdrawal, engagement in "risky" behavior such as alcohol, nicotine, and illegal drug use, anger....

Exhibit C: Viagra, the new wonder pill that reduces impotence in men by increasing blood flow to cause erection.

In its first month on the market, nearly 150,000 prescriptions for the little blue pill have been filled. Even many men who don't experience "erectile dysfunction" are trying out the stuff, as are — really — some women, who say the vascular effects of Viagra make for heightened sensation.

Never mind that 10 percent of men suffer severe headaches from the pill — can you say stroke? — as well as blurred vision and sudden collapses of blood pressure.

Pills: Surely impotent men are grateful for Viagra, but how many of them have problems because of drug, alcohol, or nicotine use? Often impotence is an early indicator of coronary disease, diabetes, even cancer.

Pills: Doctors now prescribe antibiotics so often that some scientists warn we are creating super-resistant strains of bacteria. (Will we have a pill for those?)

And more pills: Much scarier, of course, is the notion that parents are so quick to load up their "difficult" kiddies with drugs rather than address other possible causes of behavior which allegedly indicate depression. To boot, we've got tens of thousands of kids on Ritalin for attention deficit disorder, at best a vaguely described disease.

Drugs are useful and necessary, of course, but have we become a society that pops pills first and asks questions later? I'm afraid so. As the talented young man I mentioned discovered, sometimes we pop pills so fast we don't even give ourselves time to find out if there are other ways to handle our problems.

One pill makes you larger, and one pill makes you small. And the ones that mother gives you don't do anything at all.

from "Go Ask Alice"
by Jefferson Airplane

Editor's Note: The author, Clay Evans, is the son of the late Clayton A. Evans, MD, of Boulder.

Dr. Clay Evans was a member of Boulder and Colorado Medical Societies for 30 years. Our thanks to Dr. Kenneth Kahn of Boulder for seeing the article and pointing it out to us.



Responding to Medical Board Inquiries

by Robert N. Spencer, Esq.
Montgomery, Little & McGrew, P.C.

Editor's Note: This article is not legal advice, but is for general information only.

One of the most intimidating pieces of mail a physician can receive is a notice of complaint from the Board of Medical Examiners. Over time I have had the opportunity, first as counsel to the Board of Medical Examiners and more recently in private practice, to review responses doctors have made to notices of complaint. Although every response was intended to answer the complaint, many failed to do so effectively and some were even counterproductive. The purpose of this article is to identify the important aspects of an effective response.

1 Know the process: When the Board issues a notice of complaint, the physician has 30 days to respond. After that time, the complaint and response are reviewed by an inquiry panel composed of half the membership of the Board. At this initial review, about 80 percent of the complaints considered are dismissed with no further action. If a complaint is not dismissed, it may be referred for further investigation or may be referred to the Attorney General for initiation of a formal disciplinary ac-

tion. Once a complaint has been referred for further investigation or to the Attorney General, the odds of dismissal without disciplinary action are greatly reduced. Because the opportunity for dismissal without disciplinary action is greatest during the inquiry panel's initial review, you should carefully craft your response to maximize the chances for an early dismissal.

2 Be sure to respond: Incredibly, some physicians simply fail to respond at all. This is inexcusable because it gives a strong impression that the physician either doesn't care or has no defense to the complaint. Furthermore, failure to respond is itself defined by the Medical Practice Act as unprofessional conduct for which the Board may impose discipline. If, for any reason, you are unable to respond within the 30 day deadline, ask for more time. The Board will generally at least one extension. Your response certainly does not need to be lengthy. In fact, given the volume of material which the Board must review every month, it is best to limit your response to only a few pages.

3 Answer the question: It is important to "answer the question," and not duck the issue just because it may be hard to answer. Sometimes, however, the notice of complaint is vague, and may leave you guessing as to what the complaint really is about. In such cases, it is best to address what seems to be the most likely cause of concern, and then stop. If you wander too far afield in your response, you may open yourself up to a broader inquiry than would otherwise have

been necessary. If you are uncertain as to the precise scope of the complaint, advise the Board that you are addressing what seems to you to be the chief concern, and invite them to contact you again if they feel further elaboration is necessary.

4 Type your response: Although it is permissible to write your response by hand, it is unwise to do so. Handwriting is notoriously hard to read, especially for people who are not accustomed to your writing. Your response is far too important to be misunderstood. If the inquiry panel members cannot read your response, or worse misread it, your effort has been wasted or may even be harmful. Furthermore, a handwritten response is likely to be one that has been prepared in haste. Your response, however, is no occasion for haste. It needs to be carefully thought out because an ill-considered response may jeopardize your license or haunt your career for years. Typing your response will ensure that you give it more careful consideration. Also, be sure to keep a copy of your response with a notation of the date it was mailed to the Board.

5 Avoid anger and sarcasm: It is natural to feel insulted when you receive a notice of complaint, but it is important to curb the temptation to respond in an angry, sarcastic or perfunctory manner. Similarly, resist the temptation to slam the complainant, whether he be patient or peer. Keep in mind that an important object of your response is to demonstrate your professional responsibility and good

(Continued)

judgment. "Taking a shot" at the Board or at the complainant will not accomplish that goal. An inappropriate response only serves to cast doubt on that judgement and thereby inadvertently lend credibility to the complaint. If you feel you must vent your anger in writing, do so, but then lay the letter aside a day or two. After you have calmed down, reword the letter in a more professional fashion.

6 Be scrupulously accurate and honest: Your credibility is essential. Therefore, the biggest mistake you can make in responding to a 30-day letter is to be untruthful, or even "bend" the truth. If caught in a lie, your credibility is instantly destroyed and will never be recovered. From then on, all doubts will be resolved against you, and a complaint which might have been dismissed will likely be referred for investigation and possibly disciplinary action. Be aware that though responses are not routinely shared with the complainant, confidentiality of a response is not guaranteed. It is wise, therefore, to write your response with the as-

sumption that the complainant may eventually see it. It is also likely that if the complaint involves issues of patient care, the Board will ask you to provide a copy of your medical records. Do not make any changes or additions to those records. If you do, you can bet that a copy of the original version will surface, with predictable and unwelcome consequences. Regardless of your notice, the inference will be that the record was falsely altered. If you do discover that the record is missing important information, prepare a separate addendum or letter of explanation, clearly dated as to when it was made, which provides the missing information. In this way, the record can be made complete without running the risk of being accused of "altering" the records.

7 Consider consultation: Many physicians feel comfortable responding to a complaint without legal assistance, and are quite competent to do so. For many others, the assistance of an attorney may be quite helpful. If you do seek the assistance of an attorney, it is useful to

take with you a draft of your response which the attorney can then review for your signature. As is usually the case, an attorney is most effective when allowed to intervene at an early stage. Whether or not you choose to engage an attorney, I suggest you ask a trusted peer to read over your response and give you an objective opinion. Just as you would consider consulting with a peer in a difficult medical situation, take the opportunity to do so here. The peer may be able to detect flaws in your approach or tone that you have overlooked. If you chose to have someone other than an attorney review your response, remember to "black-out" names of any patients mentioned in the response in order to preserve their confidentiality.

In summary, if you receive a notice of complaint from the Board, recognize that your response is your best opportunity to dispose of the complaint. Respond in a well thought out, legible, truthful and professional manner. This will greatly enhance the chances of the complaint being dismissed.

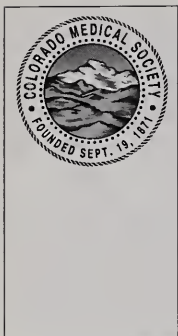
You're too busy practicing medicine to play politics

Every day you see the effects of health care reform on your practice. Every day you promise yourself that you will become more involved and help shape the future of medicine. But the truth is that sometimes you are just too busy.

Fortunately you have COMPAC. Legislators are becoming aware of and educated by organized medicine. However, the Campaign Reform Amendment and legislator turnover in both Houses in 1998 may dramatically affect the legislative advances made for you and your patients.

Join COMPAC today and become personally involved in the future of health care in Colorado. Then rest assured the voice of organized medicine will continue to be heard at the state legislature. For information call (303) 779-5455, ext. 2410 or 1-800-654-5653.





by Kristen Mahan-Moutaw, Manager
Clinical Outcomes, CNI

Outcomes at the Colorado Neurological Institute

Initiative for Clinical Outcomes in Neurosciences (ICON) Mission Statement:

The Initiative for Clinical Outcomes in Neurosciences exists to aid research in developing better treatments for neurological disease; to demonstrate quality of care; to ascertain cost-effectiveness of medical care and above all to document that the Colorado Neurological Institute and its physicians are providing for patient's needs.

Since its inception, CNI has been conducting outcomes research including collecting patient satisfaction and clinical data. In 1994, CNI launched the Initiative for Clinical Outcomes in Neurosciences (ICON) Project. The ICON Project was created in order to enhance the level of outcomes data collected, to develop reliable protocols and to provide ongoing quality assurance for each outcomes database.

The ICON Project Team designs, implements, programs and maintains full-spectrum outcomes databases and protocols for CNI's Programs and members. The ICON Project's full-spectrum outcomes research includes: collecting demographics, clinical, quality of life, patient satisfaction, referring physician satisfaction and charge variables; designing data collection tools; programming database software; mapping and implementing data collection protocols; and maintaining data quality assurance.

The ICON Project's pilot database was the CNI Epilepsy Center. The Epilepsy Center was already collecting extensive outcomes data on all of its surgical patients. The ICON

Project, working closely with Epilepsy Center physicians and staff, expanded the data collection to include all seizure patients. Currently, the Epilepsy Center's seizure database is the oldest running database at CNI. The Epilepsy database includes baseline and follow up data on more than 1,250 patients. The database also includes all monitoring, surgical, satisfaction and charge information on all of its surgical patients.

During the Epilepsy Center Pilot Project, the ICON Team quickly learned many lessons regarding designing and implementing outcomes protocols:

- It is imperative to have at least one program or clinic physician involved in all aspects of the database from design and implementation through maintenance. Physician expertise and investment is crucial to the success of the project.
- Staff members who will be responsible for coordinating the protocol should be included in the design and understand the benefits of the program.
- Collection tools for clinicians and staff should be designed to be quick to complete.
- Data entry of tools should be programmed appropriately. Tools should be quick to enter and the database should be programmed with as many quality perimeters as possible so mistakes will be few.

- When choosing variables and surveys for the outcomes program, include all that may be of need. When programming a database electronically and in collecting data, it is easier to delete variables than to add them.
- The tools and database should be created with an eye toward the dynamic. There will be advancements to medicine and treatments and the outcomes protocol needs to accommodate.
- Frequent feedback from physicians, clinicians and staff should be solicited in order to ascertain if data collected is useful, surveys used are measuring appropriate outcomes and the processes are streamlined.
- Retrospective data collection should be avoided. It is time consuming and often times faulty.
- Most costs will occur in the first year but be aware that updates and upgrades will be necessary and should be planned.
- Document all decisions not only in the preliminary design stage but also throughout the process of the protocol.
- Get started.

After the Epilepsy outcomes program and database were tested, debugged and running smoothly, the

(Continued)

ACCOUNTABILITY

(Continued)

ICON Project Team added several new databases. In 1995, the CNI Movement Disorders Center and the CNI Neurovascular Surgery Service started collecting data. The Movement Disorders Center collects data on patients with Parkinson's and to date has information regarding more than 500 patients. The CNI Neurovascular Surgery Service collects data on patients with AVMs, aneurysms and other vascular lesions and has data on more than 85 patients.

In 1996, the ICON Team worked with the CNI-HealthONE Brain Tumor Network in developing the outcomes research process of the program. Preliminary protocols were developed in that year and data collection began in 1997. The CNI-HealthONE Brain Tumor Network's outcomes database is currently following over 35 patients.

The ICON Project Team, in conjunction with its physician project

directors, works constantly with this data for many purposes. We have used our data in order to write articles and abstracts for medical journals and conferences, to present to managed care companies and referring physicians in order to show excellent patient care and satisfaction, to provide statistics on patient visits, referrals and charges, to ascertain patient satisfaction with clinics, hospitals, clinicians and staffs, to better understand the patient's perception of their quality of life and to provide reports on possible candidates for clinical research and drug studies.

The ICON Project is consistently enhancing the outcomes research program at CNI. The ICON Team is working on ways to enhance quality of life assessments and better ways for the physicians to utilize that information. The ICON Team is also strengthening the patient satisfaction data from collection once a year to twice a year in order to better track and utilize patient satisfaction numbers. The Team is working with outcomes leaders to put together a sys-

tem that will assess costs of treatments as well as the charge data already collected. Finally, at the beginning of this year, the ICON Team compiled and distributed an Outcomes Summary that includes data regarding all of its outcomes projects. This Summary will be distributed annually to physicians referring to CNI's programs, to the medical directors of managed care and insurance companies and to CNI's membership base.

The ICON Project owes its success to the supportive atmosphere provided by CNI and the placement of priority status on outcomes research at the Institute. The ICON Project also owes its success to the advocacy of physician project directors and clinic staffs for their resolution to create and maintain useful outcomes research projects with quality data. Through these and other sources of support, the CNI ICON Team can continue to provide high quality, reliable and useful clinical outcomes to CNI and its programs and members.

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ACCOUNTABILITY

"... program of audits, investigations, and inspections of facilities."

*by Lucia Hammer, RN and Kam Valentine, RN
Colorado Foundation for Medical Care*

"Medical Quality Improvement Organizations (QIOs). . ."

Addendum

With additional funding from the Health Insurance Portability and Accountability Act, Operation Restore Trust activities have been expanded into Colorado. The Department of Health and Human Services will begin its publicity "roll-out" this summer. The "campaign" has been very successful in other states because it works with those *local* agencies closest to the seniors to enlist their help in identifying fraud and abuse.

Social Security and Administration on Aging are two of the local offices that will be involved in the fraud awareness education of Medicare beneficiaries.

Medicare is one of the largest and fastest growing programs in the federal budget. Fraud is one of the reasons. Health care fraud accounts for up to 10% of all Medicare expenditures, or approximately \$28 billion in fiscal 1997.

Medicare provides health benefits coverage to 36 million individuals who are elderly, disabled, or have end-stage renal disease (ESRD). The Congressional Budget office (CBO) determined that Medicare spending in Fiscal Year 1996 totaled approximately \$200 billion and in 1997 close to \$280 billion.

Since 1992, the number of health care fraud convictions has increased by 240% due in large part to increased resources available at the U.S. Justice Department, more focused investigative strategies, and better coordination among law enforcement agencies.

These changes have taken place through a demonstration project called, "Operation Restore Trust." The project began in five states and has since expanded to the rest of the country. Operation Restore Trust is estimated to have saved more than \$20 billion in health care claims through policy changes, penalties, recoveries, claims, denials and settlements.

Operation Restore Trust relies on a nationwide program of audits, investigations, and inspections of facilities. The organizations charged with conducting this project include the Office of Inspector General, the Federal Bureau of Investigation, the U.S. Attorney offices, the Attorney General's office, State Medicaid fraud units, Medicare fiscal interme-

diaries and private insurance carriers.

Medical Quality Improvement Organizations (QIOs), like the Colorado Foundation for Medical Care (CFMC), will provide medical review services when requested, but will not actively search for fraud and abuse situations.

A key legislative proposal, if successful, could increase the effectiveness of Operation Restore Trust. The Medicare/Medicaid Anti Waste Fraud and Abuse Act of 1997 establishes tougher requirements for individuals and companies that wish to participate in the Medicare and Medicaid Programs. The legislation sent to Congress by President Clinton includes a series of changes to provider enrollment rules, stronger sanctions against fraudulent providers and the elimination of several loopholes in the law which have provided easy targets for individuals looking for a way to defraud the government. (For example, the President's plan closes a loophole in the law whereby Medicare and Medicaid providers and suppliers declare bankruptcy in order to avoid paying administrative penalties.)

Besides the President's proposals, providers should also be aware of the Qui Tam Litigation, also known as the Whistle Blower Statute. This law allows private citizens to act on the government's behalf in filing lawsuits, claiming that a party has violated the Federal False Claims Act by filing false claims with the Federal Government or a federally-funded program. Qui Tam plaintiffs may be anyone who has knowledge about the coding, billing or general

financial operations of a provider. Whistle blowers can receive up to 30 percent of the final settlement in these civil cases.

Typical Fraud Targets

- Numerous criminal complaints have been filed alleging unnecessary physical, occupational and speech therapy for beneficiaries that suffer with Alzheimer disease and senile dementia when it is clear the patient in question is unable to benefit therapeutically from these services.
- Visual aid devices are reportedly being marketed to visually impaired Medicare beneficiaries. The device works like an overhead projector and transfers enlarged images onto a television screen. Beneficiaries are allegedly being told by salespersons that Medicare will pay for this device even though the device has not been approved for coverage by Medicare.
- A medical equipment supplier has been submitting claims to Medicare for a hip abduction orthotic device which is actually nothing more than a protective pad. It is not medically necessary or a Medicare covered service/supply. In addition, the claims were submitted and payments were received by the supplier, even though a large number of the devices were refused and returned.
- The government is also investigating medical "store fronts" where no office exists. The FBI has recently committed significant resources to ferret out these companies.

Investigators utilize huge databases to do their job, fraud investigators utilize huge databases to search for "outliers." Outlier providers are those whose coding or billing practices are significantly outside the norm. For example, if the percentage of cases assigned to a particular DRG is usually 10 to 15%, but in a particular facility 60% of cases are assigned to the DRG, that facility could become the target of a fraud investigation.

When a whistle-blower identifies a possible fraudulent practice in one health care organization, investigators may examine state or national data from many facilities to identify other providers who might be involved in the same practice. If a facility involved in an investigation is owned by a corporation, the investigation may be broadened to encompass all facilities owned by this corporation because the questionable practice may reflect corporate policy. If a provider's fraudulent activity is the result of a consultant's recommendation, the investigation may encompass all of that consultant's clients.

As this article makes clear, a provider can easily become the target of a fraud investigation without anyone pointing a finger directly at him. If you find yourself embroiled in an investigation, do not panic. An investigation is just that, an investigation. It does not necessarily mean you have done anything wrong. However, your response to investigators will be less effective in shifting the focus away from you if you have little knowledge of your current coding or billing practices or if your policies and procedures are outdated. Compliance programs within provider and physician organizations can prevent costly audits and decrease the chance of being the focus of a government investigation.

To schedule an informative talk on the government's Operation Restore Trust investigation, contact Lucia Hammer, Associate Director, CFMC Medicare Program, at 695-3300 ext.3155.

Lucia Hammer is the Associate Director for CFMC's Medicare Program. Kam Valentine is the Associate Director for Communications at CFMC. Created by the Colorado Medical Society and based in Aurora, CFMC is Colorado's Medical Quality Improvement Organization.

AM 98

VFC-Provider Profile to be replaced by

The Colorado Department of Public Health and Environment is proud of the public-private partnership that has been created between the **Colorado Vaccines for Children** program and health care providers like yourself. Your participation has made this immunization initiative a success for Colorado's children.

Since the 1995 onset of the *Colorado Vaccines for Children* program, providers have been required to complete an annual Provider Profile estimating the total number of children to be immunized in each successive 12-month period. The Centers for Disease Control and Prevention (CDC) now requires the annual Provider Profile be based on actual recorded data. This is due to the special interest groups wanting to repeal the federal Vaccines for Children program because they feel it lacks adequate accountability.

In order to meet this new federal requirement, the *Colorado Vaccines for Children* program will be using the method of "benchmarking" to record the actual number of children vaccinated at each enrolled site. Each site will need to complete a "benchmarking" form, recording the age and eligibility category (e.g., enrolled in Medicaid, uninsured) for all children vaccinated there during September, 1998.

During July, the contact person at each enrolled site will receive a letter with instructions for completing the "benchmarking" form. We have tried to make this process as painless as possible because no one is happy about any additional paperwork. However, by obtaining more accurate immunization provider profiles, we will improve accountability and help this important program for Colorado's children.

The CDC and the State Health Department thank you in advance for your cooperation in this effort. Please contact Rosemary Spence, a nurse with the department's Immunizations Program at 303-692-2798.

Annual Meeting Registration

1998 Annual Meeting of the Colorado Medical Society and the CMS Alliance
September 10-13, 1998, Sheraton Steamboat Conference Center and Resort

Name (please print) _____

Component Society _____ Name of Guest(s) _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservation deadline is August 12, 1998. Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders. (Note: To attend the President's Dinner Dance on Saturday, you must obtain your tickets before noon, Friday, Sept. 11 at the Reservation Desk.)

As a member, you and one guest are entitled to attend the complimentary events at no charge. Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complementary Events for Member & Guest

Please indicate below which functions you will attend. Additional guests are welcome, costs are indicated below.

Thursday, September 10	member	guest
6:00 pm Welcome Reception	<input type="checkbox"/>	<input type="checkbox"/>

Friday, September 11		
7:00 am Rural Physicians Forum Breakfast	<input type="checkbox"/>	(members only)
8:00 am Alliance Breakfast	<input type="checkbox"/>	<input type="checkbox"/>
5:30 pm Exhibitor Reception	<input type="checkbox"/>	<input type="checkbox"/>

Saturday, September 12			additional guests
7:30 am Educational Program Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	# _____ @ \$15/each _____
7:30 am Inspirational Breakfast	<input type="checkbox"/>	<input type="checkbox"/>	# _____ @ \$15/each _____
8:30 am Educational Program	<input type="checkbox"/>	<input type="checkbox"/>	
Noon AMA Forum Luncheon	<input type="checkbox"/>	<input type="checkbox"/>	
7:00 pm President's Dinner Dance			
Meat dinner	<input type="checkbox"/>	<input type="checkbox"/>	# _____ @ \$50/each _____
Vegetarian Dinner	<input type="checkbox"/>	<input type="checkbox"/>	# _____ @ \$50/each _____
Vegan Dinner	<input type="checkbox"/>	<input type="checkbox"/>	# _____ @ \$50/each _____
8:30 pm Copic Dessert Reception	<input type="checkbox"/>	<input type="checkbox"/>	

Other Events:

Friday, September 11

Noon COMPAC/Alliance Luncheon # _____ @ \$20/each _____

Please make check payable to: **Colorado Medical Society**

Amount enclosed for additional guests and COMPAC Lunch \$ _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550); phone it to us (at 303-779-5455 or 1-800-654-5653); or fax it to us (at 303-771-8657).

1998 Annual Meeting Schedule*

Sheraton Steamboat Conference Center and Resort
September 10-13, 1998

Thursday, September 10

8:00 am	CMS Office opens
9:00 am	18-hole Golf Tournament - Sheraton Course
1:00 - 2:00 pm	Finance Committee
2:00 - 5:00 pm	Copic Seminar
2:00 - 5:00 pm	Board of Directors
4:30 - 8:00 pm	Registration
6:00 - 7:30 pm	Welcome Reception
	Dinner on your own

Friday, September 11

7:00 am	CMS Office opens
7:00 am - 5:00 pm	Registration
7:00 - 7:45 am	Reference Committee Breakfast
7:00 - 7:45 am	New Delegate Orientation
7:00 - 7:45 am	Rural Physicians Forum
7:15 - 8:00 am	COMPAC Board
8:00 am - noon	Exhibits
7:45 - 8:00 am	Credentials Committee
8:00 - 8:30 am	Opening Session - HOD
8:00 - 9:30 am	<i>Alliance Breakfast</i>
8:30 - 12:15 pm	General Membership Meeting
9:30 am - noon	<i>Alliance Membership Meeting</i>
9:55 - 10:10 am	Refreshment break
12:20 - 1:45 pm	<i>COMPAC/Alliance Luncheon</i>
2:00 - 3:00 pm	Contracts Seminar, Greg Ruland
2:15 - 4:30 pm	Reference Committee
3:15 - 5:30 pm	Reference Committee
3:15 - 4:15 pm	FP/IM Physician A Copic Risk Management Seminar, George Thomasson, MD
3:15 - 4:15 pm	General Surgery/Urology/GYN A Copic Risk Management Seminar, Richert Quinn, MD
4:00 - 7:00 pm	Exhibits
4:30 - 5:30 pm	Guidelines for the Diagnosis of Breast Carcinoma, Marjie Harbrecht, MD
5:30 - 7:00 pm	Exhibitor Reception
6:30 - 8:00 pm	Women in Medicine
6:30 - 7:30 pm	Colorado Chapter, ACP/ASIM Annual Meeting
7:00 - 9:00 pm	Gone But Not Forgotten Dinner (by invitation)

Alliance Program

Frances Weaver, a long time member of the Pueblo County Medical Alliance, simply doesn't believe that aging equates to loneliness and boredom, she's proved it and wants everyone to know it. A tireless world traveler and speaker, she has home bases in Pueblo, Colorado and Saratoga Springs, New York. Frances began writing for publication in 1950. After her surgeon husband died in 1980, facing the need to create for herself a greatly modified life-style, she went back to college to study creative writing. She does a weekly commentary for public television in Pueblo and is a regular on NBC's Today Show. In 1985 Frances received an award from the Santa Barbara (California) Writer's Conference for non-fiction.

Saturday, September 12th
9:00 - 10:00 am

Copic Seminars Scheduled for Friday

2:00 pm

Contracts

Greg Ruland

3:15 pm

FP/IM Physician

George Thomasson, MD

General Surgery/Urology/GYN

Richert Quinn, MD

4:30 pm

Guidelines for the Diagnosis of Breast Carcinoma

Marjie Harbrecht, MD

AM 98

Wayne and Mary Sotile

Recognizing the fact that CMS members wish to include their families more and allow them to be more involved in their busy lifestyle, the House has asked us to incorporate a culture that is more "family friendly". Thus, in an effort to serve our members better, CMS has scheduled a special event for this year's Annual Meeting.

Wayne and Mary Sotile will present on **Saturday, September 12 at 10:30 am, focusing on "The Medical Marriage: A Couple's Survival Guide."**

The Sotile's work together as a dynamic team presenting entertaining and thought-provoking sessions. Have you heard of the Supercouple Syndrome? If yes, then you may have heard of the book they coauthored, "The Medical Marriage: A Couple's Survival Guide," or you may have heard the critical acclaim of the Sotile's speaking at the Illinois State Medical Society Alliance Annual Meeting last April. Whether or no you have heard about them this is something you and your spouse can not afford to miss.

Take advantage of this opportunity - bring your spouse and learn together at this entertaining and informative program!

**Sponsored by the
CMS Alliance**

Everyone's Invited!
**Historical Walking Tour
and Ice Cream Social
Saturday at 2:00**



1998 Annual Meeting Schedule*

Sheraton Steamboat Conference Center and Resort
(Continued from previous page.)

Saturday, September 12

7:00 am	CMS Office opens
7:00 - 11:00 am	Registration
7:00 - 11:00 am	Exhibits
7:30 - 8:20 am	Educational Program Breakfast
7:30 - 8:20 am	Inspirational Breakfast
8:30 am - noon	Educational Program
9:00 - 10:00 am	Alliance Program - Frances Weaver
noon - 1:30 pm	AMA Forum Lunch
5:00 - 6:00 pm	Primary Care Physician Caucus
5:30 - 6:15 pm	Meet the Candidates Reception
6:15 - 7:00 pm	Inaugural
7:00 - 10:30 pm	Presidents' Dinner/Dance
8:30 - 10:00 pm	Copic Dessert Reception

Sunday, September 13

6:30 am	Reference Committee Reports available
7:00 am	CMS Office opens
7:00 - 10:00 am	Registration
7:00 - 8:30 am	Component Caucuses
	Arapahoe
	Aurora-Adams
	Boulder
	Clear Creek Valley
	Denver
	El Paso
	Larimer/Weld
	Pueblo/Western Slope
	Eastern Plains
8:15 - 8:30 am	Credentials Committee
8:30 - noon	Closing Session HOD
9:00 - 10:00 am	Alliance Gavel Club Breakfast
Noon/following HOD	Reorganizational Board

Dress for Annual Meeting

Thursday Evening	casual, black & white attire
Friday	casual
Saturday Morning	casual
Saturday Evening	Black & White Ball - Dressy business attire or tuxedo/cocktail dress optional
Sunday	casual

* NOTE

Times are subject to change. You will receive a final schedule at registration.

CMS Annual Meeting Golf Tournament

Sheraton Steamboat Golf Club
Thursday, September 10, 1998
Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____

Home Phone _____

Fax Number _____

While in Steamboat I will be staying at _____

I will be attending the meeting in the capacity of:

☐ Physician ☐ Exhibitor ☐ Spouse ☐ Other

My golf handicap is _____ or My average score is _____

Please reserve a set of ☐ Left handed ☐ Right handed clubs for me.
I will pay the \$25 rental fee on site.

If you would like to play, please return this entry form as soon as possible because space is limited. CMS has reserved tee time, starting at 9:00 am. for only eight foursomes. Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament reservation, entry form and advance payment of \$95 must be received no later than August 21, 1998. Cancellations received after August 21, 1998 are refundable subject to ability of Sheraton Steamboat Golf Club to "resell" vacated tee time.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at 970-879-1391.

I prefer to be teamed with: _____

☒ **Mail Entry Form and Check to:**
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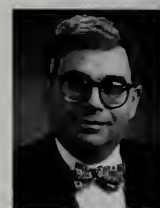
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Double Rate	\$110 + tax
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Check-out Time	11:00 am

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Building a Sense of Community With Medical Students

by Richard D. Krugman, MD
Dean, School of Medicine
University of Colorado



In my regular meetings with small groups of medical students, I ask, "What would it take for you to leave here the day of graduation with a lump in your throat?" Many students cite the need for a stronger sense of community with their peers and faculty.

Although the School's move to Fitzsimons is on the horizon, it will be some time before the Health Sciences Center campus can expect to have a place suitable for students and faculty to meet for both informal gatherings and planned workshops. As the campus enters a period of transition, the lack of community space will compound a problem already identified: students' lack of connection with the school.

Already, far too many medical students leave the campus with little to no sense of identity or community with the School. During this transition, we expect the students to be the most vulnerable group because they have no common space or gathering place.

With the goals of building a stronger sense of educational community with the School and the University, we have designed a series of two-day intensive workshops for the first, second and fourth-year classes, beginning this year. The continuum of the three workshops has been designed specifically to address major milestones in medical education:

1. *Transitioning to medical school, the first leg of the journey for fu-*

ture physicians. This set of workshops will be held immediately prior to entry into the first year of medical school. The goal is to help entering students prepare for the medical education. Topics will include establishing and nourishing mentor relationships, using information technology in medical education, and financial planning.

2. *Moving from the first two years of mostly basic science/classroom education to the final two years of clerkships in clinical settings.* Held in the winter quarter of the second year, topics include helping students think critically about their medical career development, reflect upon their educational experience to date, and prepare for the transition to clinical rotations.

3. *Transitioning from medical school to residency training.* The workshops will be held during late spring, prior to graduation. Topics will include reinforcing concepts and practices of life-long learning and reviewing the impact of the school's curriculum on students' decision-making and clinical problem solving skills. This set of workshops will serve as a major opportunity for students to gather as a group during their final two years of school.

The first of these, for second year students, was held this past January 15-17 at the University's Given Institute in Aspen. The turnout was terrific. Over 110 of 130 students participated. The Given also was the site on April 19-21 when the fourth-year medical students met. The participation was gratifying — 65 of 128 members of the Class of '98 were in attendance — particularly knowing that many were making

their final preparations for their residencies. Active members of the School's alumni board joined us in an effort to develop stronger bonds with current students. The initial set of workshops for entering students are scheduled for August 18-19 at Silver Creek.

In another effort to build and sustain a sense of community we are developing a faculty mentoring program, linking medical students with scientists and physicians for a full four years of medical school. In the School's interdisciplinary approach to education, students are not associated with a specific department or unit. This makes it difficult for students to identify a specific faculty or department mentor. This program will create a more formal, structured mentoring program to ensure that each student has a faculty member to serve as advisor and coach throughout his or her time in medical school.

These new efforts also support University of Colorado President John Buechner's Total Learning Environment themes. First, they support innovations in learning by teaching students and faculty how to develop mentoring relations and by helping students to build bridges between the clinical and basic science years. Second, they are responsive to our students and other constituents by creating a sense of community.

Additionally, they use technology to improve teaching and learning through the integration of information technology into medical education. Finally, they enhance the University's human, capital, financial and organizational infrastructure by augmenting potential alumni donor support.

Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Medicare Fraud and Abuse: Copic Has Two New Ways to Help You Cope

Unless you have been living in a cave for the last year, you have heard about the federal government's crackdown on Medicare fraud and abuse. With losses estimated at \$20 to \$28 billion annually, it is little wonder that only the fight against terrorism absorbs more of the FBI's time and energy. The information coming out of Washington -- about what is and isn't proper -- seems to be in a constant state of flux. The obvious concern for our insured physicians is that all of you who have followed the letter of the law may still be called upon to prove your integrity. That is why we now offer two NEW ways to help you cope: our Fraud and Abuse Seminar and a Fraud and Abuse Defense Costs Endorsement to the Copic individual medical professional liability policy.

Fraud and Abuse Seminar

The new Fraud and Abuse seminar was developed for Copic's Risk Management department by Anne R. Cox, Esq., an associate in the Law Offices of George D. Dikeou. (Mr. Dikeou is Copic Insurance Company's Executive Vice President and its General Counsel.) The seminar covers the critical issues for physicians:

- Upcoding; miscoding; kick-backs; "unbundling," and over-utilization of services
- Relevant federal regulations: fraud; false statements; obstruction of criminal investigations

- Potential criminal and civil penalties
- Methods of detection
- Risk management resources: compliance programs; education programs; and reporting systems

Physicians who attend a Fraud and Abuse seminar earn 1 point in Copic's Experience Rating System (ERS). Seminars last for one hour. Physicians in any specialty may attend for ERS credit. Upcoming seminar dates include:

July 14, 1998

6:00 p.m. to 7:00 p.m. Copic Insurance Company Boardroom, 7800 East Dorado Place, Suite 200, Englewood, CO 80111

Reservations required -- call Sue Turek to RSVP at 303/930-0437 or 800/421-1834, ext. 2437, or e-mail her at sturek@copic.com (be sure to include seminar title, date, and time, as well as your name).

July 25, 1998

10:45 a.m. to 11:45 a.m.

Colorado Society of Osteopathic Medicine (CSOM) meeting
Manor Vail Lodge, Vail, CO
Reservations required -- please call Patricia at CSOM to RSVP at 303/322-1752.

Fraud and Abuse Defense Costs Endorsement

In response to repeated requests from our insured physicians, Copic will soon add a Fraud and Abuse Defense Costs Endorsement to the individual medical professional liability policy. Physicians insured under individual policies will be provided with up to \$25,000 in reimbursement of defense costs incurred in relation to fraud and abuse investigations, peer review activities, and Board of Medical Examiners activities.

The individual must satisfy a deductible and must secure services from an approved list of attorneys. Due to the nature of the risk, physicians insured under group policies will be handled slightly differently. They, too, will be required to secure services from an approved list of attorneys; however, deductibles and aggregate limits will be factored based on the number of physicians in the group.

Our plans currently call for the endorsement to be available before the end of August. Watch your mail for an announcement of the official launch date.

AM 98



Medicare fraud and abuse

Clarifications in the carrier's role

by Marilyn Rissmiller,
CMS Dept. of Health Care Financing

As the government's activities surrounding the investigation and prosecution of health care fraud continue to be of concern to physicians, including the CMS President-elect, we are re-publishing this article on "Medicare fraud and abuse". The article is still pertinent and supplemented by the following information will bring you up-to-date.

Documentation and coding

The timing of the release of Medicare's revised E & M documentation guidelines was such that it coincided with the heightened publicity concerning the government's "war" on health care fraud and abuse. The result was that physicians looked at these guidelines much more critically than they had the previous set and overwhelmingly said "NO!" The revised guidelines are currently undergoing a drastic rework and the implementation has been postponed, at least one year.

Medicare officials respond

From the head of the Health Care Financing Administration (HCFA), Nancy Ann Min DeParle, to the Medicare Medical Director for Colorado, Dr. Grant Steffen, officials state that they will not prosecute a physician for [E & M] coding errors.

But be assured, they **will** deny the claim or ask for money back if the documentation does not support the code submitted. HCFA implemented the random pre-payment audit of E & M documentation last fall. The preliminary results seem to demonstrate their point, that even under the old guidelines, the physician's documentation does not justify the level of E & M code billed.

Health Insurance Portability and Accountability Act

This spring, HCFA released its Request for Proposal for contractors interested in participating in the new Medicare Integrity Program. This program is designed to split the claims processing functions from those of the utilization review.

In June 1998, the Department of Health and Human Services released proposed regulations for the Incentive Program for Fraud and Abuse Information that is scheduled to start 1/1/99. Under this program rewards will be paid to Medicare beneficiaries who report fraud and abuse.

CMS staff continues to monitor these important issues and are available to answer any questions you may have. You can call Marilyn Rissmiller in the Health Care Financing Department at 779-5455 or 1-800-654-5653, ext. 2428.

Grant Steffen, M.D., the Medicare Medical Director for the state of Colorado, clarifies the carrier's role in fraud and abuse.

He advises that, "Charges of fraud and their implementation **are not brought by the carrier**. I cannot charge anyone with fraud. This task is handled by the Inspector General's office or the FBI. The carrier **can** refer a provider to these agencies for their consideration.

...I would make such a referral **only** when the provider continues, after an educational effort by the carrier, to engage in fraudulent activity. **I would not make a referral just because of an honest mistake or confusion over the interpretation of Medicare rules."**

In response to a question raised at the May 15, 1997 meeting of the Colorado Carrier Advisory Committee, regarding what actions are taken when upcoding is found, Dr. Steffen explained there are three ways it may be handled. "First, education may be done, with a recheck of records in six months. Second, education and recoupment of the difference between what was billed and the service provided per documentation for the charts reviewed. Third, if there appears to be a serious problem a comprehensive medical review may be done, resulting in education and a projected overpayment for the entire period of review with recoupment. ...Of course, at any time, if the situation warrants, there may be a fraud referral."

(Continued following page)

In the previous articles in *Colorado Medicine* information has been provided on the Medicare Focused Medical Review (April 1997) and on the definitions of fraud and abuse used by the Medicare Carrier (May 1997). Here we will address the Health Insurance Portability & Accountability Act (HIPAA) and how it has expanded the fraud and abuse statutes and sanctions. The fraud and abuse provisions of the law took effect January 1, 1997.

1. The new law increases the sanctions that may be imposed for violations of the fraud and abuse statute. Some of these include:
 - Mandatory exclusion for felony convictions in connection with the delivery of a health care item or service or involving controlled substances.
 - A minimum, three-year exclusion for convictions of misdemeanor criminal health care fraud offenses, criminal offenses relating to fraud in non-health care federal or state programs, convictions relating to obstruction of an investigation, and convictions of misdemeanor offenses relating to controlled substances.
 - A minimum one-year exclusion for people who provide items or services in excess of the needs of a patient.
 - Increases in the maximum civil monetary penalty from \$2,000 to \$10,000 per service, and increases in the maximum assessment from twice the amount claimed to three times the amount claimed.
 - Increases in the civil monetary penalties for falsifying home health claims.
2. The Medicare and Medicaid civil money penalties were expanded to cover all federal health care programs. The law also expanded the circumstances when penalties may be applied, for example:
 - Practitioners who show a pattern of presenting claims for items or devices based on a code that the physician knows (or should know) will result in greater payment than the physician knows (or should know) is applicable for the items or services actually provided (**upcoding**).

- Practitioners who bill for services that they know are not medically necessary. The maximum civil monetary penalty applicable has increased from the actual cost to up to \$10,000 for each occurrence.
3. The HIPAA establishes criminal sanctions for health care fraud applicable to both government and private payers. It adds health care fraud to the criminal code, and defines a federal health care offense as a violation of (or criminal conspiracy to violate) specific provisions of the U.S. Code, if the violation relates to a health care benefit program.
 4. New programs have been established to enhance the federal government's ability to investigate and prosecute fraud and abuse:
 - A Fraud and Abuse Control Program under the jurisdiction of HHS to coordinate existing federal, state and local programs that combat fraud and abuse.
 - A Medicare Integrity Program that will contract with outside entities (that may or may not be Medicare carriers) to review the activities of providers who receive Medicare payment - including medical, utilization and fraud reviews.
 5. Beneficiaries will be encouraged to report fraudulent activities through an incentive program.
 - The beneficiaries currently contact the Medicare carrier when they feel they did not receive a service that shows up on their Explanation of Medicare Benefits. According to the carrier, the majority of these reports are either due to a misunderstanding of the services listed or incorrect information on the billing (e.g., wrong health insurance claim number or incorrect date of service). You can avoid these "referrals" by educating your patient about the services ordered and billed, as well as verifying the accuracy of the information submitted.

Organized medicine was successful in getting Congress to adopt language to clarify that physicians and other providers can be sanctioned only if the person "acts in de-

liberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth or falsity of the information." It was **not** the intent of legislators to "penalize the exercise of medical judgment of health care treatment choices made in good faith, and which are supported by significant medical evidence or held by a respectable minority of those providers who customarily provide the service. The Act is not intended to penalize providers simply because of a professional difference of opinion regarding diagnosis and treatment."

This is the first time that upcoding has been defined as a fraud and abuse violation that could be subject to civil monetary penalties. However, the "deliberate ignorance" and "reckless disregard" language should protect physicians from being sanctioned for unintentional or inadvertent coding errors or differences of opinion regarding the use of a particular code, since there is a burden of proof that must be established.

Physicians must know and follow the CPT definitions and documentation guidelines. A physician who chooses not to read or follow the CPT definitions may not be protected, because this could be considered deliberate ignorance. Similarly, a physician who ignores repeated notices from a carrier that they are consistently billing a wrong code may not be protected, because this could be considered reckless disregard.

Although the emphasis on fraud and abuse continues to grow, from the perspective of the Colorado Medicare Carrier and a representative of the local Office of the Inspector General, it is not "their" intent to penalize anyone for honest, unintentional mistakes. If you have specific questions, or would like additional information you can contact Marilyn Rissmiller in the CMS Health Care Financing Department at 779-5455 or 1-800-654-5653, ext. 2428.

Excerpts were taken from the American Society of Internal Medicine's report on the HIPAA.

T

OUCH THERAPY

by Thomas H. Coleman, MD,
Denver



**... leisurely professionals
and faith are hard to find
among today's hurried
doctors and nurses.**

The recent publicity for "touch therapy" prompted questions from a former patient, and my own search for the answers. TV and print news have shown and described touch therapy, which is mysteriously "effective" without touching. Therapy happens when operators pass their hands, at a respectful distance of eight inches, through the air above a fully-dressed and reclining client, supposedly detecting and intercepting invisible "energy fields" emanating from the body. Some operators claim their hands accumulate "bad" emanations, often in a layer so thick that the operator has to rinse or shake them off between passes. Results are better if the operator thinks healing thoughts.

The existence of these "fields" has not been demonstrated by scientific study. A skeptical nurse in Loveland, Colorado devised a grade-school experiment for her nine-year-old daughter, showing that without looking, practitioners of touch therapy could not detect nor guess the supposed presence or location of a person's alleged "energy fields" more than half the time. That's an accuracy no different from guessing heads or tails during tosses of a coin. The report was printed this April in the *Journal of the American Medical Association*, concluding that the practice of touch therapy based on theory of energy fields is groundless, unjustified in the name of professional scientific medicine.

Has a little child led us through science to reality? Could she be distant kin to the legendary boy who observed that his emperor in expensive "new clothes" was actually naked? Is the invention of human en-

ergy fields, subject to cleansing by motions of the hands, asking too much from the credulity of people not schooled in scientific medicine?

This ingenuous theory and practice, a sort of "laying off" of hands, is spreading among some nurses and other practitioners, with implied supervision in hospitals (two in Denver), or by independent operators charging significant (and uninsured) hourly fees. The cult boasts an organization, Healing Touch International, of Lakewood, Colorado, that sponsors training classes. An official of the Colorado State Board of Nursing says that nurses already licensed need no special Board Certification to become touch therapists.

Without touch or energy fields, why do clients say they feel better after a session, and are glad to pay for it? Because for patients, leisurely professionals and faith are hard to find among today's hurried doctors and nurses. For an hour in a quiet place, these practitioners show concentrated and welcomed attention to people who are in medical trouble and anxious for reassurance from a professional. Except to convince a client they are "doing" something, practitioners probably wouldn't need their odd theory of energy fields. The passing of hands may be art. It is not science.

I hope that clients of touch therapy, and their practitioners, will take care that their illnesses already have a diagnosis and conventional treatment. No alternative therapy can be justified merely by claiming it does no harm. It can do harm if it wastes a client's time and money in false hopes while delaying timely access to scientific medical attention.



When you make the decision...

American Medical Association
Physicians dedicated to the health of America

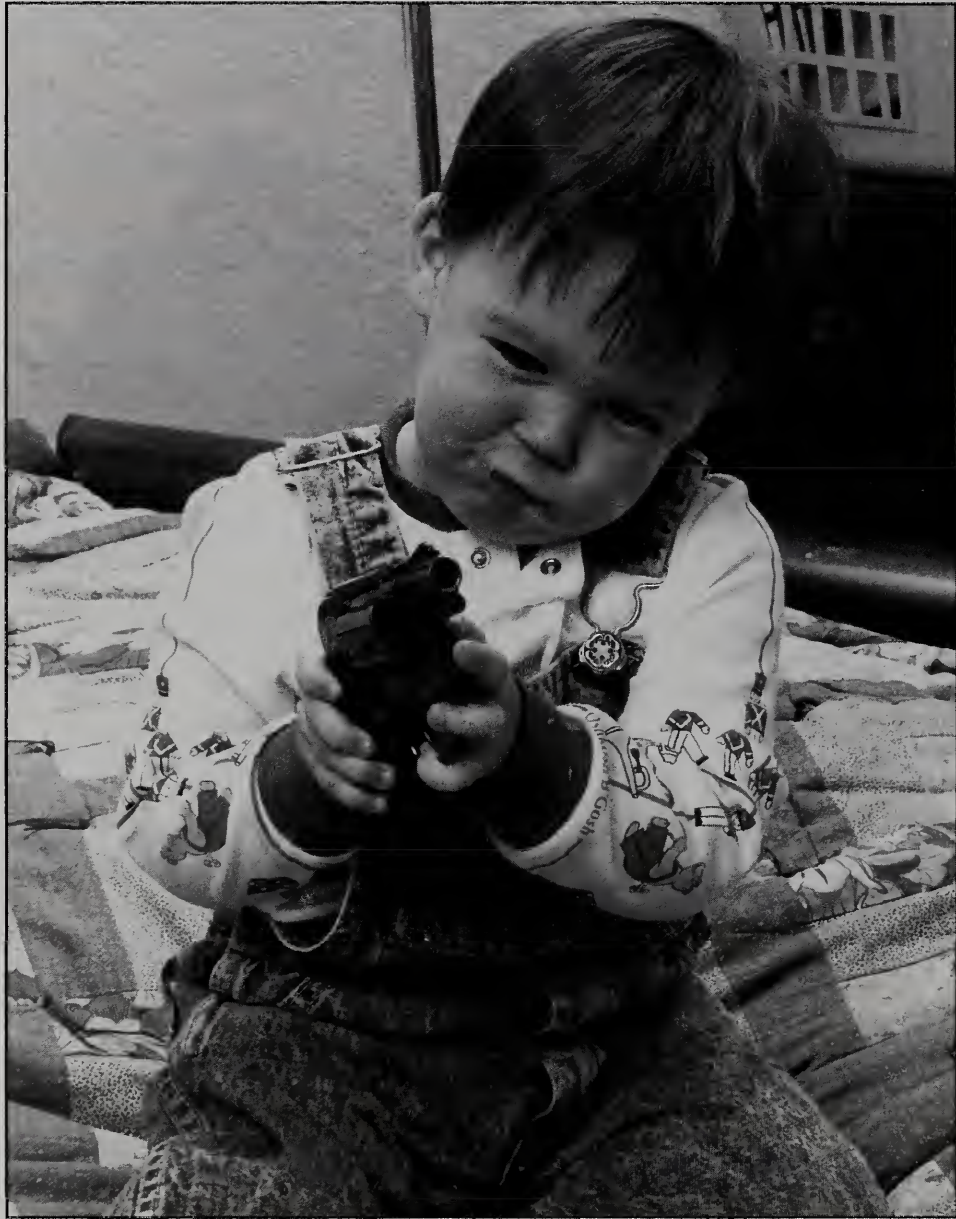
Closing Your Practice

Department of Practice Development Resources

... here's the book you need, to do it right!

The AMA Department of Practice Development Resources has made available this booklet giving you the fiscal, legal and ethical answers to all those questions when you decide to close your practice. You can order the book by calling 1-800/621-8335. The order number is OP381689RY. Price of the book is \$19.95 for AMA members, \$24.95 if you are not a member.

Kids and Guns Just Don't Mix...



Doctor, are you talking to parents about guns in the home?

Remember:

Separate guns and ammunition,

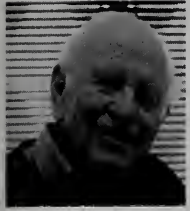
Lock up guns and ammunition separately,

Use trigger locks

If you keep a gun, empty it out, lock it up!

This message brought to you by the Colorado Medical Society,
Task Force on Youth

For more information call Suzi Shevell at 303-930-0407 or 1-800-654-5653



by John L. Lightburn, MD
Historian, Colorado Medical Society

A Magic Place; the Ancient City of Padua

Those of you who enjoy Shakespeare will remember that in his play, *The Taming of the Shrew*, Petruchio, a gentleman from Verona, pursued and tamed Katerina in the narrow streets of Padua. And those of you who know your religious history well can identify Padua as the city of St. Anthony where the faithful erected the magnificent basilica named for St. Anthony; and you art historians know that Giotto created his greatest frescoes in the Arena Chapel in Padua. Maybe some of you slept through those lectures on the history of medicine. Here is your chance to learn what you missed. And for those of you who have never heard of Padua, read on.

Padua is where Mrs. Lightburn and I spent a recent holiday... a memorable holiday that is the inspiration for this month's *Archives* column. Although there is no mention of Padua in the Colorado Medical Society archives, I beg your tolerance as I relive the magic of that ancient city.

Padua's origins date back over 2000 years to the beginning of the Roman empire. Called Patavium by the Romans, it was a city with many canals which joined the Adige, Brento and Po rivers. It prospered and grew to be second to Rome in size and wealth. When the Roman empire disintegrated, Padua was overrun by the Lombards in 601 A.D. Surviving the misery and chaos of the Dark Ages, it again became an important city by the 11th century. It established itself as a free commune (unlike our modern use of the term "commune", medieval communes

were cities and towns with charters giving them the liberty to govern themselves) and remained a commune through the 12th and 13th centuries. Free from the repressive rule of civil and ecclesiastic authorities, it prospered and quickly became an economic and cultural center. It continued to thrive and retain freedom of inquiry and thought under the rule of the munificent Carrara family, 1312 to 1406, and then under the domination of the fabulously wealthy aristocracy of Venice, 1406 to 1795. Following

Padua became both a university center but also a cultural and artistic center



Anatomical Theatre (in detail), School of Medicine, University of Padua, built in 1594.

that, it declined under the foreign rulers such as the Hapsburgs in Vienna.

(Continued next page)

ARCHIVES (CONTINUED)

In about 1218, a young Portuguese Franciscan friar, Anthony, came to Padua, preaching eloquently and working miracles. He died at age 36 (1237) and was canonized a year later. This gave rise to the building of the magnificent six domes Basilica of St. Anthony. At about the same time (1222), a group of students and teachers, fleeing from the "grievous offense that was brought to bear on the academic liberties and failure to acknowledge the privileges solemnly granted" by the University of Bologna, found in Padua a receptive and congenial place to establish a new university, not born "ex privilegio" (i.e., by special license from the Pope or Emperor). Thus was the beginning of one of the great universities of Europe.

Padua became both a university center but also a cultural and artistic center. Its prosperity gave rise to a class of wealthy elite. One of these was a merchant named Scrovegni, who apparently offended Dante Alighieri who retaliated by placing Senor Scrovegni in the 7th Circle of Hell in the *Inferno* section of his epic poem, *The Divine Comedy*. It was this merchant's son, Enrico Scrovegni, who brought Giotto to Padua to create those magnificent frescoes in the Arena Chapel (Capella degli Scrovegni) (1303-1307). With this "gift of God", he had hoped to rescue his father from this terrible plight. In those days, may people took Dante's judgments very seriously. The result was an artistic masterpiece that attracts many people to Padua today.

As inspiring as these famous frescoes are, I spent more time exploring the narrow arcaded streets of the ancient city. The Italians do not replace their old buildings with new modern structures; they save them as national treasures. As we explored, we would frequently encounter large numbers of bicycles and motor scooters parked next to an ancient structure, which marked a building of the University. The center of the University was the

Palazzo del Bo, which I will describe in more detail later in this article.

Here is a brief historical review of the University. From the beginning, the university was a uniquely democratic institution where the students drew up the statutes, elected a Rector and appointed and paid their own faculty. At first, only studies in law and theology were offered, but the school grew rapidly and soon offered courses in medicine, philosophy, astronomy, grammar and rhetoric. In the 13th century, the University was sustained by the commune. During or shortly after the 20 years of the devastating Bubonic plague or "Black Death" in the 14th century, the wealthy Canarese family supported the institution, and from the 14th to the 18th century support came from the Venetian republic. For almost six centuries, Padua remained uniquely free of repression and control of

large marble stele honoring the students who died fighting for Italy's independence from 1845 to 1945. At the foot of the marble steps to the first floor, you see a statue of Elena Lucrezia Cornaro Piscopia, the first woman in the world to receive Ph.D. (1678). Climbing to the first floor, you pass through crowds of nervous students and their parents who are awaiting their turn for the oral examinations for their doctoral degree. Here we enter the anteroom of the "Galileo Galilei" Great Hall, a room large enough to accommodate the crowds that came to see and hear the great scientist lecture. More about Galileo later. On the opposite side of the Palazzo, we find the large circular, seven tiered Anatomy Auditorium or amphitheater large enough to accommodate over 100 students while the professor demonstrated various anatomical structures. The story is told that the ecclesiastic authorities would allow only two

human bodies to be used annually. More bodies were provided by energetic grave robber (poverty stricken medical students?) There is a trap door under the dissecting table through



Anatomical Theatre, University of Padua Medical School

inquiry and experimentation. The University ranked with Paris, Cambridge and Oxford as a great cultural centers of the western world. It was the Gymnasium Omnium Discipoinarim.

As mentioned above, the University has been centered in the Palazzo del Bo, formerly a famous 14th century inn in Padua. Now restored, it is truly an inspiring and magical place to visit. Entering the ancient courtyard, you encounter a

which illegal bodies could be dropped to avoid discovery by the authorities. The amphitheater had been built over one of the canals.

Although the ancient buildings of the University are impressive, it is faculty and students that created Padua's reputation as the birthplace of modern science. Here is a sampling of those who participated in the beginning of the "scientific revolution" that continues to this day:

Born in Torun, Poland, Nicolas Copernicus (1473-1543) studies astronomy at the University of Krakow and then traveled to northern Italy to experience for himself the wonders of the Renaissance. He found Padua much to his liking and spent several years there where he studied medicine and canon law, apparently receiving degrees in both subjects. He also lectured on mathematics and astronomy in Padua and in Rome. In 1512, he settled in Frauenburg, East Prussia where he practiced medicine (his astronomical studies did not pay well) and was appointed canon of the local cathedral. Practicing medicine by day and studying the stars and planets by night, he used his mathematical genius to solve the puzzle that his observations presented. By 1530, he had completed the treatise on the structure of the universe and the solar system, which he dedicated to Pope Paul III. The treatise was not published, however, until 1544 when he was fatally ill, and it is unlikely that he ever knew the furor he had created.

Andreas Vesalius (1514-1564), a Flemish anatomist, left his home in Flanders in 1537 to continue his anatomical studies in the medical school in Padua. Although it had been decreed that only two human bodies could be dissected each year, grave robbers, probably enthusiastic students, provided a steady stream of anatomical specimens. It was in Padua that this Flemish genius published "*De Humani Corporis Fabrica*", his anatomical findings that challenged the teachings of Galen (c. 130-c. 200). For over 13 centuries, no one had dared to question the validity of the great Galen! He had been the physician to the court of Marcus Aurelius and had published over 500 papers on philosophy and medicine. But the courageous anatomist from Padua did what nobody else had done and broke the yoke that had blocked progress in medicine for 1300 years. Vesalius was severely criticized for questioning the blind acceptance of Galen's teachings.

There was another revolutionary at Padua. Galileo Galilei (1559-1642) had studied medicine at the University of Pisa, but had found physics and mathematics much more interesting. At age 23, his stature as a physicist, scientist and mathematician had been established by his experiments concerning the effect of gravity on falling objects and pendulums. In 1592 at age 33 he was invited to teach at Padua where he studied and taught until 1610. Crowds of students came to hear him lecture. Here, he built his first telescope and made the observations of the planets and the sun which confirmed the Copernican concept of the solar system. Galileo was so pleased with his new discovery that he wanted to tell the world. After leaving Padua, he took his telescope to Rome to show it to the Pope (1616). In Rome, however, the inquisitors did not greet his discovery with enthusiasm. They advised him not to publish his findings. By 1632, he could no longer keep silent and published his findings confirming the Copernican theory. Such heresy could not be tolerated and in 1633, he was tried by the inquisition and found guilty. Would this have happened if he had stayed in Padua where Venice frequently defied the Papacy and Rome.

When Vesalius retired from Padua to become physician to King Charles V, he left his best student, Gabriello Follopio to continue his teaching and research, giving his name to an important organ in the female pelvis. After Follopio came Hieronymus Fabricius (1537 - 1619) who was William Harvey's teacher! It was during Fabricius' time that the famous anatomic theater was built.

William Harvey (1578-1657) came to Padua from Cambridge and received his medical education at Padua. It was also at Padua that he did his research into the function of the heart and circulatory system. Lacking a microscope, he did not understand the capillaries, but he understood the rest of the system and described it accurately in his paper. After completing his work in

Padua, he returned to England to establish a medical school there.

Giovanni Babbista Morgagni (1682 - 1771) was professor of anatomy at Padua for 56 years, was the founder of pathologic anatomy. He was a meticulous observer and recorder, he contributed many classical descriptions of pathological anatomy which are the basis for modern medicine. He carried out exhaustive post-mortem examinations and his influence is perpetuated by his chief work "*De sedibus et causis morborum*" (1761).

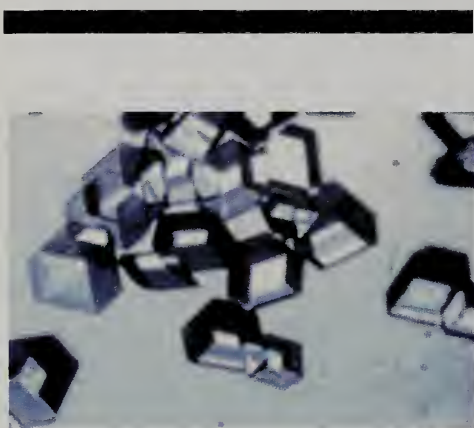
Other famous graduates included: Thomas Linacre (1460 - 1524), physician and humanist, first president of the Royal College of Physicians and physician to Henry VIII; Olof Rudbeck the Elder, (1630 - 1702), professor of botany, anatomy and medicine at the University of Uppsala; Thomas Bartholin, of Denmark (1616-1680), founder of the Danish medical school and published a thorough description of the lymphatic system; Peter V. Postnikov, sent to Padua by Czar Peter the Great in 1692, Russia's first physician with an M.D. degree; Emanuele Sciascian, first Armenian to attend Padua, (1775-1858), physician to the Imperial Court in Constantinople and promoter of the first institute of medicine in Turkey.

In 1545, the University established the first botanical garden, at first devoted to the growing and study of medical plants. Collecting plants from all over the world, it remains to this day an exquisite garden with an impressive collection. Today, University of Padua is a part of the Italian system of higher education and has a student body of 60,000. Its medical school has a fabulous heritage, and the world owes a great debt to it for its centuries of contributions to science and medicine. You may think overly romantic, but I found becoming reacquainted with these medical giants a magical experience.

PAX VOBISCUM!

S

pace Grown Insulin Crystals



Through space research, scientists have grown the largest insulin crystals ever studied. From these large crystals, researchers are gaining a clearer vision of insulin's vital form and function — leading to better treatments for diabetic patients.

Diabetic patients may someday reduce their insulin injections and lead more normal lives because of new insights gained through innovative space research in which the largest insulin crystals ever studied were grown on the Space Shuttle.

Results from a 1994 insulin crystal growth experiment in space are leading to a new understanding of diabetes. This has the potential to significantly reduce expensive treatments, since treatment of diabetes accounts for one-seventh of the nation's health care costs. Sixteen million Americans suffer from hormone deficiency diseases such as diabetes, hepatic failure, hemophilia, Parkinson and Huntington diseases.

"The space-grown insulin crystals have provided us new, never-before-seen information," said Dr. G. David Smith, scientist at Hauptman-Woodward Medical Research Institute, in Buffalo, N.Y. "As a result, we now have a much more detailed picture of insulin," Smith said.

Because of the increase in crystal size, Smith's team is able to study in more detail, the delicate balance of the insulin molecule. Natural insulin molecules hold together and gradually release into the human body. With some of the new and unexpected findings, researchers may be able to improve how insulin is released from its inactive-stored state to its active state. This could greatly improve the quality-of-life of people who are on insulin therapy by cutting down on the number of injections they have to take.

"This new information can be

used in the development of a new therapeutic insulin treatment for the control of diabetes," said Smith.

Hauptman-Woodward is partnering with the Center for Macromolecular Crystallography, a NASA Commercial Space Center, in Birmingham, Ala.

"We are doing crystal growth experiments in the near-weightlessness of space that really tell the story of how insulin works and give us clues of how, in the long run, to defeat diabetes," said Dr. Marianna M. Long, associate director of the center located at the University of Alabama at Birmingham.

Insulin is one of the most important hormones in the human body because it regulates the body's blood sugar levels. In people with diabetes, insulin is not produced in sufficient quantity, nor regulated properly. This metabolism disorder impairs the body's ability to use digested food for growth and energy.

Current treatment is to inject the insulin hormone. However, the peaks and valleys in insulin levels can lead to serious health problems, including blindness, lack of circulation, limb amputations and kidney failure.

Like many chemicals in the body, the three-dimensional structure of insulin is extremely complex. The intricate, blueprint-like arrangement of atoms within the insulin molecule determines how well the hormone interacts within the body. When grown on the ground, insulin crystals do not grow as large or as ordered as researchers desire — obscuring the blueprint of the insulin molecules.



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Who's

WATCHING OUT For You?

From providers to community leaders, researchers to educators, and government officials to citizens, the National Rural Health Association's members seek to improve the health care of rural Americans through advocacy, communications, education and research.

The National Rural Health Association and its members work to overcome rural health care challenges. They focus on reforming and strengthening health care to meet the needs of rural areas. While government funding continues to dwindle, this multi-disciplinary group of health professionals and leaders finds innovative solutions to complex dilemmas.



NATIONAL RURAL HEALTH ASSOCIATION — *Caring for the Country*

For more information, contact the NRHA,
One West Armour Boulevard, Suite 301, Kansas City, MO 64111;
816-756-3140; fax 816-756-3144.



MEDICAL NEWS



Dr. Jack Berry receives the Walking Stick award from Dr. Felice (Gus) Garcia. The award honors Dr. Berry for his distinguished career in family medicine.

Dr. Jack L. Berry was honored recently as the newest recipient of the High Plains Walking Stick award. Dr. Berry is the third recipient of the award, which is presented biannually by the University of Colorado School of Medicine, Department of Family Medicine to a distinguished family physician. The award includes a \$4,000 grant to be used for the improvement of rural health care.

The High Plains Walking Stick award was created by Dr. Felice "Gus" Garcia in honor of his father who was a rural family practitioner in Colorado during the late 1800's. The walking stick represents the

durable and hard working characteristics of rural family physicians. The walking stick is crafted from the hardwood of a small tree called Osage orange, it is said to be one of the few plants able to withstand the harsh environment of the high plains.

Dr. Berry plans to use the \$4,000 grant to advance obstetrical services in rural communities. He says, "There are a number of rural hospitals that have been working toward completing their obstetrical systems. All they need is a little help with equipment and setup. These monies will go a long way to improve the services in these areas."



Dr. and Mrs. (Dick and Jean) Bedell work together with compassion for others.

Richard and Jean Bedell recently received the Boulder Rotary Club Compassion Award. The award is in recognition of the Bedell's exceptional services in volunteering their time and talents. By trait Dick is a pediatrician and Jean is a nurse with a specialty in gerontology, but their livelihood is humanitarianism.

In 1990 Dick sold his pediatric practice in Boulder in order to devote more time with Jean to volunteering in third world countries. Dick provides much needed physician services while Jean as a mediator and registered nurse teaches conflict resolution techniques and is an instructor in colleges of nursing.

Twenty years ago Dick and Jean realized that they wanted to devote their time to provide care for the poor

in third world countries. In September of this year they will embark on their eighth trip to India. Dick and Jean spend at least two or three months a years volunteering their services.

Dick also received the Daily Camera's 1998 Pacesetter Award for making significant contributions in medicine.

Editor's Note:

Dr. Bedell was a member of the CMS Board of Directors and was elected as Speaker of the House of Delegates, in which office he served for two terms. He then was elected President of CMS (1986-87).

Jean Bedell was one of the first Colorado mediators in out-of-court resolutions and focused attention on Boulder as a developmental center for negotiated settlements.



Colorado physician K. Mason Howard has been awarded the Peter Sweetland Award of Excellence by the Physician Insurers Association of America (PIAA). The award is given annually to an association member who embodies the high ideals and ethical standards exemplified by the late Peter Sweetland, a founder of the PIAA.

Dr. Howard, an orthopedic surgeon, became the first chairman and CEO of Copic Trust/Copic Insurance Company in 1981. COPIC is Colorado's leading provider of medical professional liability insurance. During his chairmanship, which lasted until 1994, he is credited with convincing the Colorado Legislature to pass one of the strongest tort reform packages in the nation.

In a nomination letter, Dr. Jerome M. Buckley, chairman and CEO of COPIC, wrote, "True leaders can not only announce their vision and find the willing talent, the much-needed treasury and the required tools to carry out that vision, but also accomplish the same with uncompromising values and principles. K. Mason Howard was such a leader."

Dr. Howard is a member of the American Academy of Orthopaedic Surgeons and the American Medical Association. He has worked with the Colorado Medical Society (president 1980-'81) and Arapahoe Medical Society (president 1975-'76). Dr. Howard also served on the Governor's Task Force on Medical Malpractice (1987-'88).

K. Mason Howard, MD Wins Peter Sweetland Award



News on Colorado Compensation Insurance

In mid May Colorado Compensation Insurance Association (CCIA) began outsourcing its medical bill payment functions on a temporary basis to CorVel; a local managed care company. CorVel will continue to price CCIA medical bills according to the state mandated Workers' Compensation fee schedule, and CorVel will issue payments on behalf of CCIA.

CCIA is in the process of converting to a new Medical Payments System and they feel this interim arrangement will allow them to have better control over the inventory and timeliness issues that normally develop during a conversion. The new system is in the testing phase and if all continues to go well, it should be operational later this summer. Once it is fully operational, you will again see payments being issued by CCIA.

If you notice any problems you feel may be related to the interim processing arrangement, CCIA would like to know about them. You can contact Bonnie Cahoon at CCIA on 782-4511, or you can contact Marilyn Rissmiller at CMS on 779-5455 or 1-800-654-5653, ext. 2428.

Unnecessary Prior Authorization

The Colorado Medical Society's Managed Care Task Force (MCTF) is looking at the issue of unnecessary requests for prior authorization from health plans. If you feel hassled or frustrated regarding a procedure that needs prior authorization and is never or seldom denied, please let the MCTF know. Please let us know the procedure, name of the health plan, and any information you feel is pertinent. If you have any questions please call Edie Register at (303)779-5455 or 1-800-654-5653.

Please fax your information to: Edie Register, Director Health Care Financing Department. Fax number (303) 771-8657.



EXERCISE YOUR RIGHT



**Vote in the Primary
August 11th!**

Attention Voters

Colorado Primary Election date is Tuesday, August 11th. Colorado physicians and their families are urged to consider voting by absentee ballot if there is a chance you may not make it to the voting booth. You may contact your local County Election Commission or County Clerk of Courts to obtain an absentee ballot. The Colorado Medical Political Action Committee (COMPAC) Board of Directors has endorsed a number of candidates based on (1) voting records of incumbent candidates; (2) personal interviews with the candidates; (3) personal recommendations of CMS members, and (4) statistical analysis of the districts. You may contact staff of the CMS Department of Government Relations for information on candidates in your area (1-800-654-5653 or 779-5455, Ext. 2410 or 2427.)

Hantavirus Update

Editor's Note: The following is a follow-up to the "Hantivirus Bulletin" printed in the June issue of Colorado Medicine from Richard Hoffman, MD, State Epidemiologist and the State's Chief Medical Officer.

Recent Western Slope trapping operations have confirmed a marked increase in the number of deer mice in Colorado this year including some found to be infected with hantavirus, reported the Colorado Department of Public Health and Environment.

Dr. Richard Hoffman, state epidemiologist and Colorado's chief medical officer, said these findings and two recent deaths in Colorado from hantavirus make it particularly important that Coloradans living in rural areas of the state regularly take precautions when working in barns, sheds or other out buildings and when around observed rodent droppings.

According to Hoffman, late May 1998 trapping operations near Durango in La Plata County captured 39 deer mice, of which nine were infected with hantavirus. In the northeastern corner of Mesa County at the same time 59 deer mice were captured, of which 11 were infected with hantavirus. In mid-June 1997 at the La Plata County location, seven deer mice were trapped, of which three were infected with hantavirus. At the Mesa County location in mid-June 1997, eight deer mice were captured, of which one was infected with hantavirus.

The two sites are among three in the state where deer mice trapping operations have been conducted since 1994. The work is done by Dr. Charles H. Calisher, a Colorado State University professor and virologist.

Results from the third trapping location, which is in Las Animas County's Pinon Canyon in Southern Colorado, will be available by July 1. Traps are left at each location for three days at a time.

John Pape, a State Health Department communicable disease epidemiologist said, "We are seeing dramatic increases in deer mice population levels compared to the past several years. People must be extremely careful this year."

Of the 13 cases of hantavirus in Colorado since 1993, a total of 9 or 69% have died. The death rate nationally from hantavirus is 44%. The two most recent Colorado hantavirus deaths involved a 38 year-old Durango woman who died on June 12, 1998, and a 17 year-old Teller County youth who died April 15, 1998.

Hantavirus was first recognized in 1993 when five Coloradans were diagnosed with the disease and four died. In Colorado in 1997, there were two cases of hantavirus but no deaths.

AM 98

**September 11 - 13, 1998
Steamboat Springs**

COLORADO MEDICAL SOCIETY ONE HUNDRED YEARS AGO



***IN 1898**

Colorado Medical Society, then 27 years old, had 511 members.

***IN 1998**

Colorado Medical Society, now 127 years old, has 5,260 members.

In 1898, Colorado had been a state only 22 years, and the economy and population base was chiefly agricultural and mineral, which meant that the majority of people were working with their hands in decidedly rural parts of the state.

In 1998, one hundred years later, a large percentage of Colorado's population still lives in rural areas, few of whom depend on agriculture or mining economies, but who still have one major factor in common.

Neither then nor now do 100% of Colorado's residents have necessary and proper medical treatment at hand; both then and now, they suffer a shortage of medical practitioners domiciled in these rural areas of the state.

What IS different about 1998 is that Colorado Medical Society has created
C.R.O.P. (Colorado Rural Outreach Program)

to fulfill the medical needs of the state's many rural areas, but your help is needed. CROP Foundation is anxious to have your help in this program to place physicians in the rural areas of Colorado.

***IN 1998**

there is no good reason why CMS can't help supply the physicians necessary to the rural populations through CROP (Colorado Rural Outreach Program) Foundation, if you will participate by contributing your time and knowledge.

Please...call or write for details on how you can help.

Contact the Foundation office at (303) 930-0407 or 1-800-654-5653, extension 2407



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◆ MISCELLANEOUS

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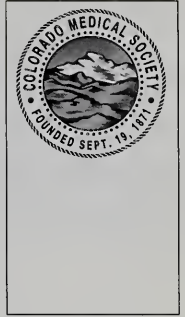
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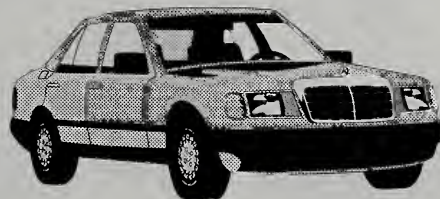
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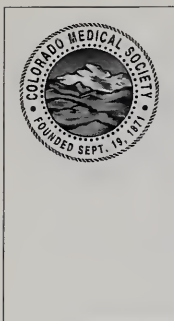
The **Colorado Medical Society** now provides a professional fleet management service to assist members throughout the state when purchasing or leasing a new vehicle. This service provides valuable vehicle information such as factory invoice costs, available options, technical data, consumer reports, etc.

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Colorado Medical Society



RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

Now here's something I can really get my teeth into...

... however, I had better hurry while I still have teeth.

I'm talking about my "**mem-oirs**". Did I talk about them some time before? Well, that's another factor that should prod me to write my memoirs now... before I also lose my memory.

Even if I have already said all this and don't remember, I think it's worth repeating. Besides, you probably won't remember, either.

That reminds me of a quote: "It's hard to be nostalgic when you can't remember."

Anyhow, some years ago I was struggling **within** myself **about** myself: here I was, I thought, at some chronological turning point, and I didn't know where I'd come from, much less where I was going. It frustrated me. I was thinking I had wasted a lifetime. Then one night I came home late from work (naturally) and I had to take a minute or two to unwind. I sat down in front of the television and started the typical channel surfing. I landed on the Johnny Carson Show and saw his guest was **Kirk Douglas**. Here's a

man I had long admired for what he had done with his life. At the time he had just turned 65 and he was talking about his memoirs, recently published. That wasn't the part that interested me; it was **why** he wrote his memoirs. Douglas said he was urged by others to write about his life, and he did so grudgingly. When he got started though, he discovered that he **had** done something with his life, and that he **had** passed through very logical and worthwhile turning points in his life. Writing his personal story, he said, was good for him, helping him put his life in order.

This lifted me up! I started thinking "What have I to be ashamed of? Why should I not be proud to look back, even on the numerous pathetic foibles I had committed and which are a part of everyone's life?" If there is shame to account for, then write about it! Writing is an excellent exorcist.

Since that night I have told many people that this is what I'm doing and they ought to be doing. Everyone has a story to tell, and everyone is different from everyone else, which is what makes life so interesting.

Sure, if you are a physician reading this then you feel you can't relate the stories of your professional life because you were brought up on "confidentiality" and "physician-patient relationship". Fine, but there's a much more interesting story about how and why you became a physician. These are the stories your family and others need to hear. Herein lies much of your story's beauty.

I am often fascinated by physician friends who tell me stories of their past and their families. In the workaday world, we don't see past the professional physician nor guess the depths of the individual. I love to hear the personal stories of my longtime friend and family physician; we have traded stories and experiences across cultural lines for years, and it is a beautiful thing.

Every human has a story to tell, and if you don't tell yours (transcribed on paper or something) now, your story could be lost forever. Sure, there are others who have lauded you as a professional, but few of them will record your stories.

There's merit in the idea that we leave a "paper trail" of our lives. I certainly have, because I have been writing and publishing all of my adult life and, good or bad, it is a fairly indelible record of where I have been and what I did.

Recently, a psychologist said that men of power in the corporate world like to inflate their own stories, typical of the Horatio Alger tale of pulling yourself up by your own bootstrap thing; *i.e.*, "I came from a dismal childhood, etc." Psychologists say they do this to make themselves seem bigger than life in their corporate roles. That's actually not necessary for anyone to do.

Our individual stories need not be colored (or discolored) to be interesting. Generations which follow us will see the stories and events in differing lights. Whatever your age, you should start **now!**

Don't wait for your teeth to go!



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"Advocating excellence in the profession of medicine"

September, 1998

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of the

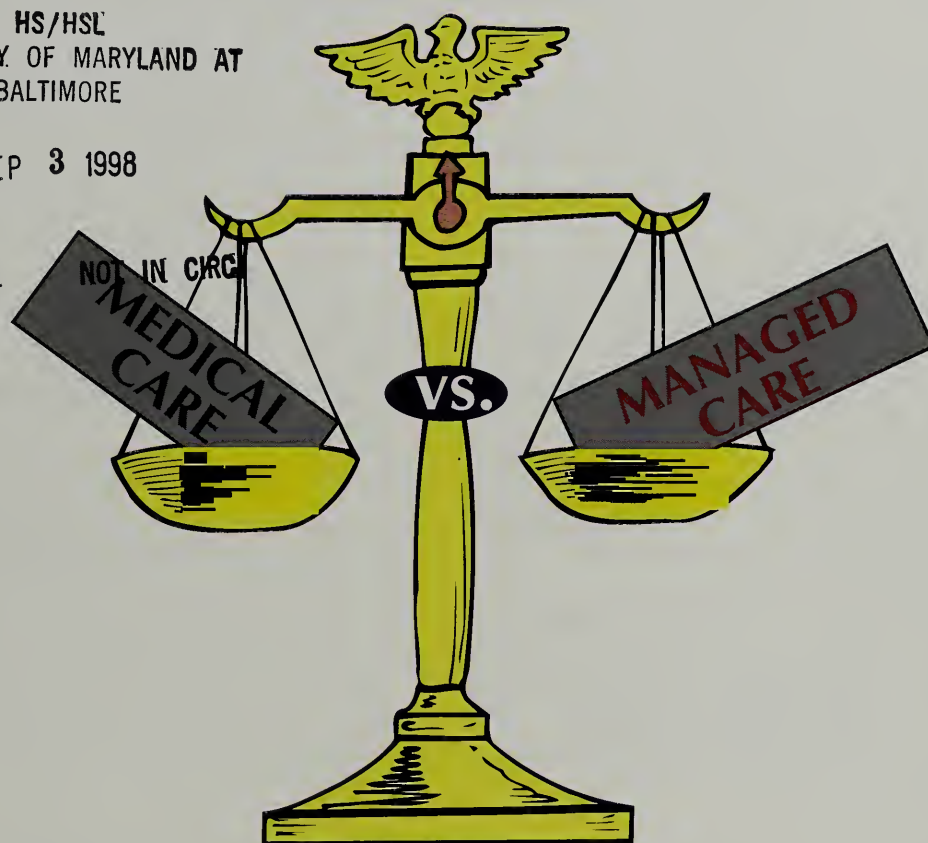
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Physicians keeping them in balance

"Managing Managed Care" featuring
Haavi Morreim, Ph.D. and Alice G. Gosfield, Esq.

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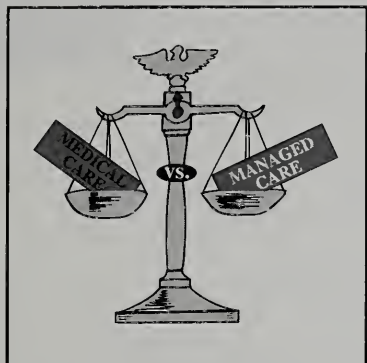
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COLORADO MEDICINE

August, 1998

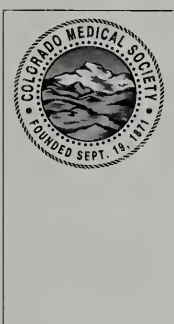
Volume 95, Number 8



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Coping with the critical balance between requirements of quality care and demands of business-for-profit in managed care isn't easy. We'll hope to ease some of these problems at the CMS Annual Meeting. *See pg 265.*



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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor, Janet Scardamaglia, Communications Assistant.

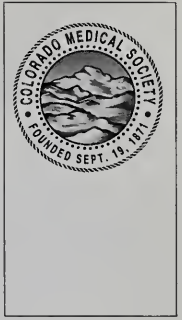
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Gary D. VanderArk, MD
President, 1987-1988
Colorado Medical Society

I continue to hear a lot of grousing in the doctor's lounge about how bad things have gotten in medicine. It seems like some doctors have fallen into a funk of self-pity and have an attitude of dispirited surrender. Then I read about a poll of Minnesota physicians in which 47% would not advise a qualified college student to pursue medicine as a career and I really got disgusted. So here I go at another attempt at what I think medicine needs.

Last month, I made a plea for leadership that is caring, organized and wise. This month let's just concentrate on caring. Medicine must recapture the joy of practice and the love of patient care. We need a revival and a recommitment to the primacy of patient needs.

Victor Frankl was a Jewish psychiatrist practicing in Vienna during the Nazi invasion of Austria. He lost everything. His family was killed and he was shipped off to Auschwitz. He had a horrible inhuman existence doing slave labor. After liberation he wrote these words:

"Life ultimately means taking the responsibility to find the right answer to its problems and to fulfill the tasks which it constantly sets for each individual"

Frankl's philosophy of existentialism was that each of us has an important role to play in life, each of us is responsible for his/her actions, and each of us controls his/her own destiny.

I would not begin to compare managed care with Nazi Germany, but I think Frankl has wisdom for us today. I think he would have said "Stop moping and get to work."

We have never had it so good! Physicians' incomes are rising, not falling. Hours worked by physicians are going down, not up. Never had we had at our disposal such an incredible armamentarium of weapons to fight disease. We live in a world of unsurpassed knowledge and new medical breakthroughs happen daily. Our abilities to diagnose and treat our patients have never been greater. What a wonderful time to care for patients!

Then look at the new generation of physicians. There really is hope for medicine. One of the joys of being president of CMS is that I was asked to help in the hooding of the graduates of the University of Colorado School of Medicine. At this ceremony a brief biography of each graduate is read by Dr. Nancy Nelson. What a great bunch of young physicians!

The students selected a new Physician's Oath which has replaced the Hippocratic Oath. These grads say it like they really mean it. Take a minute to read it because it will give you new hope.

REFERENCE:

1. Frankl, Viktor, *Man's Search For Meaning*
Beacon Press, 1962 pp 98-99.

PHYSICIAN'S OATH

As I don the hood of physician these things I promise:

I will educate my fellow humans so they may avoid illness, and whenever possible, I will prevent disease in the recognition that prevention is far better than cure.

I will counsel my patients to the best of my ability, and apprise them of all medical and social options, my own personal biases aside.

I will avoid arrogance for it is dangerous, and I will avoid the temptation to believe that my opinion is always the right one.

I will not treat a patient when I am not qualified to do so. I will be quick to call upon my colleagues for advice, and I will be quick to render aid when asked.

I will use medical resources wisely, for they have limit.

I will remember that death is not my enemy but is the natural end of life.

I will promote ethical conduct within my profession.

I will help teach my colleagues and future generations of physicians.

I will remember that in addition to being a physician, I am also a citizen of my country and my world. I will speak out when silence is wrong. I will recognize that disease is not limited to the individual but afflicts all humanity. I will fight ignorance and injustice as well as disease.

Though I will be dedicated to medicine, I will remember my family and those close to me. I will celebrate the gift of life.

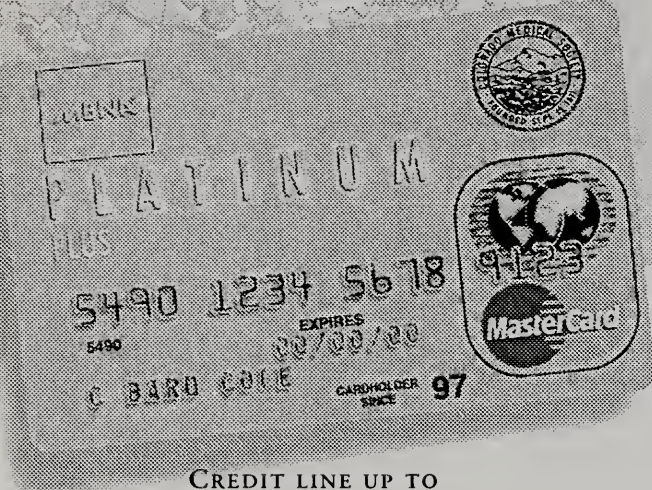
I make these promises solemnly, freely and upon my honor.

...anon 5/98

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Employer _____	Position _____	Years there _____	Source of other income† _____
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Total household income \$ _____	

†Alimony, child support, or separate maintenance income need not be revealed if you do not wish it considered as a basis for repayment.

X _____ Date ____/____/____
MY SIGNATURE MEANS THAT I AGREE TO THE CONDITIONS APPEARING ON THIS FORM.

Please complete only if you have moved or changed employers in the last three years.

Previous Address _____	City _____	State _____	ZIP _____
Previous school or employer _____	Years there _____		

Annual fee	None.
†Annual Percentage Rate (APR)	14.99% fixed for purchases.
Grace period for repayment of balance for purchases	At least 25 days, if each month, we receive payment in full of your New Balance Total by the Payment Due Date.
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Transaction fee for purchases	Transaction fee for the purchase of wire transfers, money orders, bets, lottery tickets, and casino gaming chips: 2% of each such purchase (minimum \$2).

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Unless I write to MBNA at PO Box 15342, Wilmington, DE 19850, I agree that MBNA and its affiliates may share information about me or my account for marketing and administrative purposes. I am at least 18 years of age. I consent to and authorize MBNA and its affiliates to monitor and/or record my telephone conversations with any of their representatives to better ensure quality service. I understand that if this credit card application is approved for an account with a credit line of less than \$5,000, I will receive a Preferred Card.

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CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax[®]

by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

CompuTour '98: Partnering with Technology for Improved Medical Care

Course Description: Through five on site visits (field trips), physicians will be provided hands-on and didactic information relative to use of computer technology in medical practice. The series has been designed for physicians desiring to increase their knowledge about computer technologies related to the practice of medicine.

Registration/Cost: There is a \$125.00 charge for attendance in this series. **This charge includes five, hands-on CME activities and a ticket to the Denver Medical Library Medical Informatics Fair.** Your registration must include completion of the technology usage survey. The survey has been designed for the purpose of designing instruction to meet your level of knowledge in various aspects of technology. Registration for the entire series is required; registration for individual activities is not possible at this time.

Schedule/Faculty

(All activities are 9:30 to 11:30 a.m.)

Saturday, October 10

Kaiser Training Center

Saturday, October 17

Kaiser Westminster Clinic

Saturday, October 24

Denison Library (UCHSC Campus)

Saturday, November 7

Medical Group Management Association (MGMA)

Saturday, November 14

Center for Human Simulation

Faculty

Lynne M. Fox, A.M.L.S., M.A.

Outreach Librarian, Denison Memorial Library,
University of Colorado Health Sciences Center

Cynthia M. Kiyotake, M.A.

Library Resource Center Director
Medical Group Management Association

Jeffrey S. Rose, MD

Director of Clinical Information Systems, Kaiser
Permanente Rocky Mountain Division

Victor M. Spitzer, Ph.D.

Director, Center for Human Simulation, University
of Colorado Health Sciences Center

Objectives

Kaiser Training Center: Demonstrate and provide instruction on use of the integrated medical record. Show how all ordering and notes are put into the computer. Introduce use of this technology for outcomes measures.

Kaiser Westminister Clinic: Demonstrate use of this technology in a clinical setting.

Denison Library: Individualized instruction will be determined through an assessment tool registrants are required to complete. Possible instruction will include: choosing an internet service provider (ISP), how to determine what equipment is needed, advanced searching/filtering skills and tools, internet protocols, use of Web browsers (Netscape, for example), how to evaluate Web sites, etc.

Medical Group Management Association (MGMA):

The Internet: How to find practice management information and resources. Locating cost management and patient satisfaction training. Your office staff is urged to attend this portion of the series (at no additional charge).

Center for Human Simulation: How to access the Visible Human and use it in medical practice. Each participant will be given brief opportunities to perform virtual medical procedures.

CME Credits The Colorado Medical Society is accredited by the Accreditation Council for CME to sponsor continuing medical education for physicians. The CMS designates this continuing medical education activity for up to 10 hours in Category 1 credit towards the AMA PRA.

Registration Form

Please fill out the form below and mail it with payment and completed skills assessment form (required for attendance). **Deadline: August 20, 1998**

Name _____

Mailing Address _____

City/State/Zip _____

Phone # _____ E-mail address _____ Fax _____

Specialty or Title if Administrative Medicine _____

Make check payable to CMS and mail to:

Colorado Medical Society, Attn: Medical Informatics, P O Box 17550, Denver CO 80217-0550

For more information contact Suzi Shevell: 393-930-0407; or Lorraine Heth: 303-930-0409.

Please complete the following survey along with your registration for this CME Series. The survey has been created for the purpose of designing instruction to meet your level of knowledge in various aspects of technology. Identify which of the following technologies you use, if you use them within your medical profession and/or personally and to what degree you use them.

Scale: 0-5 (0=do not use, 1=rarely, 5=daily).
Please check or circle those that apply.

1. Computer Usage: Administrative/Clinical Practice

Do you use a computer at your desk in your medical office?

0 1 2 3 4 5

Do you use a computer in your exam room?

0 1 2 3 4 5

Does your staff use a computer for practice management purposes?

0 1 2 3 4 5

Are your medical records computerized? If yes, indicate how many years back?

None _____

Some _____

Significant degree _____

Paperless office _____

2. Do You Use the Internet?

Professional

0 1 2 3 4 5

Personal

0 1 2 3 4 5

Do you have skills to conduct electronic searches for accessing medical information? (e.g., latest research for particular diagnosis, latest treatment options, etc.)

0 1 2 3 4 5

3. Do You Use E-Mail?

Professional Colleagues

0 1 2 3 4 5

Patients

0 1 2 3 4 5

Personal

0 1 2 3 4 5

4. Do You Use CD ROM?

Professional

0 1 2 3 4 5

Personal

0 1 2 3 4 5

Patient Education

0 1 2 3 4 5

5. Do You Use Telephone Conferencing (3 or more people)

Professional

0 1 2 3 4 5

Personal

0 1 2 3 4 5

6. Do you use interactive multi-media technologies (excluding home entertainment) for use in:

CME

0 1 2 3 4 5

Patient Education

0 1 2 3 4 5

Other/Please describe:

7. Do You Use Videoconferencing?

Professional

0 1 2 3 4 5

Personal

0 1 2 3 4 5

8. Do you Provide Tele-consultations?

Telephone

0 1 2 3 4 5

Video

0 1 2 3 4 5

E-Mail

0 1 2 3 4 5

Your candid additional comments regarding use of technologies in medical practice are welcome.

Accountability in practice: Collaborative Data Project on Diabetes' story of success

The CMS Collaborative Data Project on Diabetes held a very successful educational conference in June. The conference, sponsored by Copic Insurance, capped more than a year of work by CMS members and managed care organizations (MCOs) to develop data profiles that physicians can use for educational purposes to improve their practices. The profiles analyzed four different processes of care and were generated using administrative claims data from participating MCOs. The conference also analyzed the Colorado Clinical Guidelines Collaborative's *Guidelines for the Treatment of Diabetes Mellitus*. The guidelines provided the basis by which a protocol was created. Four processes of care were studied: 1) GHB one or more glycosylated hemoglobin or HbA1c measurements per year; 2) two or more visits to a primary care provider per year; 3) one or more dilated eye examinations per year; and 4) one or more formal urinalyses per year.

Attendance was high and participation at the conference was strong. Over 40 physicians participated and another 25 will receive audiotapes of the proceedings. Attendees learned more about the impetus for the project to collaborate with health plans to develop uniform evaluation and reporting standards. Donald Daeke, MD, and Dan Bessessen, MD, led discussions on how the diabetes guidelines were created and evaluated. Attendees lauded the development of a uniform guideline and the accompanying decrease in paperwork and hassles associated with using many different guidelines. Participants encouraged the participating plans and CMS to do more work in streamlining the information development and dissemination process.

Howard Shapiro, PhD, analyzed the statistical significance of the data study and Bonnie McCafferty, MD, Co-chair of the Collaborative Data Project on Diabetes, reviewed the preliminary data findings from the project. Although there were some discrepancies in data retrieval, in general the summary statistics re-

ported scores that were similar and in some cases superior to the benchmark scores from a literature review. Nine MCOs participated in the project including: Aetna, Cigna, Colorado Access, HMO Colorado, Kaiser Permanente, Pacificare, Qualmed, Sloans Lake and United Healthcare. The study population encompassed over 25,000 diabetics in Colorado and over 1,100 practicing physicians. The study period was September 1, 1996 – August 31, 1997. MCOs will remeasure next year. Physicians received profiles of their practice from participating plans that detailed their scores in comparison to the average rate across all plans for the four indicators. Those average rates compared across all the plans for the indicators are: 1) GHB – 62.1%, 2) PCP visit – 78.0%, 3) Dilated eye – 47.4%, and 4) UA – 49.8%.

Patient and physician confidentiality are cornerstones of the project. Therefore, physicians received separate profiles from each of the plans with which he or she is contracted. Attendees brought all of their profiles to the conference and utilized a computer terminal to calculate their mean scores across all the plans. In this way attendees were able to obtain information that aggregated their confidential data from multiple MCOs to develop a more accurate profile of their entire practice.

A panel of high performing physicians then overviewed their practice techniques and answered questions from the audience about why they scored so well. High performers included: Howard J. Kerstein, MD (Denver), Peter I. Monheit, MD (Denver), Thomas G. Johnson, DO (Fountain), Cindy Ireland, MD (Westminster), and Gregory F. McAuliffe, MD (Alamosa).

The Collaborative Data Project on Diabetes educational conference emphasizes the interest in and merit of joint projects between physicians and managed care organizations. Accountability and practice quality can be enhanced with proper leadership and assurances for the protection of patient and physician confidentiality.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

The 24th Annual Tutorials in the Tetons: New Concepts in Cardiology - sponsored by American College of Cardiology

August 24-26, 1998
Grand Teton National Park, Moran, Wyoming
Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

Menopause: A Rapidly Changing Scene

September 19, 1998
Inverness Hotel & Golf Club
Englewood, Colorado
Contact: Joanne Sherman at HealthONE CME
(303) 360-3320

Fall Clinics of Montrose, Colorado

September 25-26, 1998
Montrose Memorial Hospital
Montrose, Colorado
Contact: Kathy Holman
(970) 240-7397

15th Annual Santa Fe Colloquium on Cardiovascular Therapy - sponsored by American College of Cardiology

October 8-10, 1998
Eldorado Hotel
Santa Fe, New Mexico
Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

Medicine in the Rockies

October 17-18, 1998
Cheyenne Mountain Conference Resort
Colorado Springs, Colorado
Contact: Erma Francois
(719) 776-5184 or ErmaFrancois@centura.org

The Association of Managed Healthcare Organizations 1998 Fall Forum

October 11-13, 1998
J.W. Marriott Hotel
Washington, DC
Contact: Elisa Ricciuto
1-800-642-2515 or www.amho.org

Communicating Expectations: Patients & Physicians

October 21, 1998
Holiday Inn Denver Southeast
Denver, Colorado
Contact: Mary Fletcher
(303) 695-3399 or mfletch@cfmc.org

Physician Finance University - sponsored by Paramount Physician Network, Century Capital Group & SKB Business Services

October 22 & 29, 1998
Doubletree Inn
Aurora, Colorado
Contact: Tracy
(303) 355-9050

Clinical Diabetes & Endocrinology

January 24-28, 1999
Snowmass Conference Center
Aspen/Snowmass, Colorado
Contact: Donna Loy
(303) 789-9682 or 1-800-421-3756

The 6th Annual Echocardiographic Workshop on 2-D & Doppler Echocardiography at Vail - sponsored by American College of Cardiology

February 22-26, 1999
Vail, Colorado
Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

18th Annual Big Sky Pulmonary & Critical Care Medicine Conference

March 24-27, 1998
Big Sky Ski Resort
Big Sky, Montana
Contact: Conference Director
(406) 442-6556

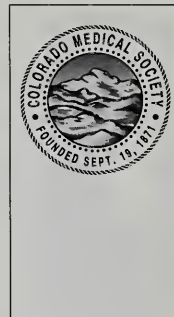
Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society



Going through some copies of *Colorado Medicine* from previous years, I happened across one containing an address given to the El Paso County Medical Society Annual Meeting in 1985 by Dr. Ray Stecker. He was the outgoing President. His address was titled **"A Startling Announcement In Reverse."**

Dr. Stecker had let on (prior to the meeting) that in his speech he was going to announce his resignation from Colorado Medical Society. Instead, Dr. Stecker said "I, for one, have weighed the evidence and cannot resign, but must actively support our society." Well, that was 13 years ago.

I was looking for comparisons – what the society was like before I became the Executive Director – between CMS of "then and now", to evaluate today's society. Have there been favorable changes? I've been asking myself: do we have a productive organization which is cost-effective and worthwhile to physicians?

Dr. Stecker was naming off the activities and advantages of membership in both his county and the state medical societies. I believe the advantages of county society membership are self-evident, so I'm looking only at CMS.

Today's CMS mirrors the 1985 organization in many ways, but many other of today's CMS attributes weren't available in 1985. You say you want to know these advantages of membership? **I was beginning to think you'd never ask!**

- Yes, you can still obtain a sizable discount on your Copic malpractice insurance through CMS membership. In

addition, Copic Insurance (created by CMS) has grown into five separate companies, each providing support to your practice in one form or another.

- Yes, dues have **decreased** substantially since 1985, and yet today CMS offers more direct membership benefits.
- Yes, there are numerous community benefits provided by your state society:
 1. A single voice for over 5,000 Colorado physicians on issues before the state legislature (imagine what the 120 day session would be like if even 1% of our membership were there to testify on each bill which impacts medicine and health care).
 2. A substantial (over 50%) success record in the legislature of passing or squelching health related bills as directed by the CMS Council on Legislation and Board of Directors.
 3. The Medically Underserved Coalition and a highly successful group of providers.
 4. Participation in the Colorado Health Professions Panel and work toward developing leadership and management skills in health organizations and practices.
 5. Coordination with the Colorado Department of Health and Environment on immunization, epidemiology, environmental hazard programs, and many others.
 6. A leaner but still more efficient CMS staff.
 7. Much more participation (by FAR) in the American Medical Association House of Delegates and national policy, not just because of the individual Colorado Delegates, but because CMS has become much more actively involved in national issues of health care and medical practice.
 8. Continues to support activities of local medical societies on local issues, without shoving anything state-wise down anyone's throat, or claiming state authorship/ownership.

"Who can best address these problems in the future?"

9. CMS handles a large number of patient/physician grievances yearly which never have to be mediated or arbitrated in court.
10. CMS/Copic/Gadrian offers an individual physician credentialing which can be used for patient information.
11. CMS works closely with the Board of Medical Examiners on a variety of issues, having developed the Colorado Physicians Health Program (CPHP), helping to educate and rehabilitate physician members who have substance abuse or other matters interfering with their practice.
12. CMS established the Colorado Physician's Educational Program (CPEP), helping physicians in continuing medical education and other matters of substandard practice.

NOTE: Both of these programs have attracted national attention and, in more than one instance, have served as models for establishment of similar programs in other states.

SO... these are a few good reasons (and there are many more) why you should be proud of your organization's record as a community member and as an integral part of medical practice in Colorado.



Fee Splitting: Clarification

Taken from the Code of Medical Ethics, Current Opinions with Annotations,
AMA Council on Ethical and Judicial Affairs, 1996-1997 Edition

6.02 Fee Splitting. Payment by or to a physician solely for the referral of a patient is fee splitting and is unethical.

A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company, or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source.

In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed. (II)

Issued prior to April 1977.

Updated June 1994.

Kan. App. 1985 Members of a

medical partnership sought an injunction to enforce a covenant not to compete against defendant-physician, a former partner. Defendant asserted that the covenant was void as against public policy relying on Opinion 9.02 (1984). The court, however, ruled that the covenant was reasonable as defined by precedent and that it was bound to follow this precedent as opposed to the American Medical Association's position regarding such covenants. Defendant further argued enforcement of the covenant was precluded because the partnership had violated ethical norms, apparently referring to Opinions 6.03 and 6.04 (1984) [now Opinions 6.02 and 6.03], which were part of partnership contract. The court held that defendant was estopped from complaining about the partnership's actions due to his own conduct. *Axtell Clinic v.*

Cranston, No. 56,745 (Kan. Ct. App. June 20, 1985) (LEXIS States Library, Kan. File).

Mass. 1955 Plaintiff-physician was charged under state licensing statute by defendant-board with conspiracy and fee-splitting. Both parties sought a declaratory judgment as to whether the defendant-board had jurisdiction to determine plaintiff's guilt or innocence. In holding that the board was qualified to determine if plaintiff's actions constituted "gross misconduct" under the statute, the court referred to Principles Ch.I, Secs. 1 and 6 (1947) [no Principle II and Opinion 6.02] delineating, in part, limitations on payment for medical services. These provisions, the court said, reflected the medical profession's understanding of its "pe-

culiar obligations." *Forziati v. Board of Registration in Medicine*, 333 Mass. 125, 128 N.E.2d 789, 791.

Journal 1985 Focuses on the importance of patient autonomy in medical decision-making. Initially describes how existing doctrines protect the value of autonomy in the context of the physician-patient relationship, then examines various problems in the current protective scheme. Case law is evaluated wherein enhanced protection is afforded to patient autonomy. Concludes by recommending the creation of an independent articulable protected interest in patient autonomy. Quotes Principles II and IV. Cites Opinions 4.04 (1984) [now Opinion 8.08] and 6.03 (1984) [now Opinion 6.02]. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 Yale L.J. 219, 275 (1985).

6.03 Fee Splitting: Referrals to Health Care Facilities. Clinics, laboratories, hospitals, or other health care facilities that compensate physicians for referral of patients are engaged in fee splitting, which is unethical.

Health care facilities should not compensate a physician who refers patients there for the physician's cognitive services in prescribing, monitoring, or revising the patient's course of treatment. Payment for these cognitive services is acceptable when it comes from patients, who are the beneficiaries of the physician's services, or from the patient's designated third-party payer.

Offering or accepting payment for referring patients to research studies (finder's fees) is also unethical. (II)

Issued prior to April 1977

Updated 1994 and June 1996 based on the report "Finder's Fees: Payment for the Referral of Patients to Clinical Research Studies," issued December 1994.

Kan. App. 1985 Members of a medical partnership sought an injunction to enforce a covenant not to compete against defendant-physician, a former partner. Defendant asserted that the covenant was void as against public policy relying on Opinion 9.02 (1984). The court, however, ruled that the covenant was reasonable as defined by precedent and that it was bound to follow this precedent as opposed to the American Medical Association's position regarding such covenants. Defendant further argued enforcement of the covenant was precluded because the partnership had violated ethical norms, apparently referring to Opinions 6.03 and 6.04 (1984) [now Opinions 6.02 and 6.03], which were part of partnership contracts. The court held that defendant was estopped from complaining about the partnership's actions due to his own conduct. *Axtell Clinic v. Cranston*, No. 56,745 (Kan. Ct. App. June 20, 1985) (LEXIS, States Library, Kan. File).

6.04 Fee Splitting: Drug or Device Prescription Rebates. A physician may not accept any kind of payment or compensation from a drug company or device manufacturer for prescribing its products. The physician should keep the following considerations in mind:

(1) A physician should only prescribe a drug or device based on reasonable expectations of the effectiveness of the drug or device for the particular patient.

(2) The quantity of the drug prescribed should be no greater than that which is reasonably required for the patient's condition. (II)

Issued March 1980.

Ohio 1980 A physician charged with violating the state medical licensing statute by distributing controlled substances without a proper license and writing prescriptions for narcotics in the name of one person when they were intended for another, challenged the state medical board's decision to suspend his license and place him on two years' probation. Under the statute, a physician could be disciplined for various activities including "violation of any provision of a code of ethics of a national professional organization" such as the American Medical Association. The board found in part that the physician's actions violated Principles 4 and 7 (1957) [now Principles II and III and Opinions 6.04 and 9.04]. The trial court reversed, holding that the board had insufficient evidence for its decision, and

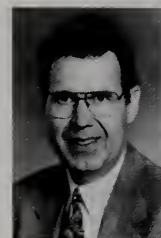
the court of appeals affirmed. On appeal, the supreme court held that expert testimony was not required at a hearing before a medical licensing board because they were experts and could determine for themselves whether the Principles had been violated. *Arlen v. State*, 61 Ohio St. 2d 168, 399 N.E.2d 1251, 1252, 1253-54.

Journal 1992 Surveys federal and state anti-kickback and anti-referral statutes pertaining to drug and device marketing activities. Considers the effectiveness of regulatory safe harbors. Reviews the AMA's ethical guidelines concerning gifts to physicians from industry. Quotes Opinion 6.04. References Opinion 8.061. Kirschenbaum & Kuhlik, *Federal and State Laws Affecting Discounts, Rebates, and Other Marketing Practices for Drugs and Devices*, 47 Food & Drug L.J. 533, 560 (1992).

Colorado Medical Society Principles of Medical Ethics

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the Colorado Medical Society are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
- V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.



by David M. Martz
President CPN

Response to Further Medicaid Losses

In April, 1998, RMHMO announced its withdrawal from Medicaid participation in Arapahoe, Adams, and Jefferson counties (except those patients in the Provenient network) due to 1997 losses of \$2.7 million. RMHMO Medicaid participation was preserved in Denver and Douglas counties at that time.

Subsequent experience has demonstrated continued major losses in the Front Range metropolitan areas, forcing expansion of the withdrawal to now include Denver and El Paso counties. RMHMO cannot continue to absorb these losses. Efforts to obtain relief from the state have been unsuccessful. Adverse enrollment with small

numbers of high cost recipients without balanced participation of healthier members destroys the economic principles of capitated managed care.

All CPN physicians have been notified in writing by mail of this development, and those with 10 or more Medicaid enrollees have been contacted personally. If desired, CPN physicians may maintain continuity of care of their RMHMO Medicaid members by encouraging them to choose one of the three options in which the physician participates:

1. The state Primary Care Physician Program (PCPP); or,
2. The state Medicaid fee-for-service pro-

gram; or,

3. Another managed care program that provides Medicaid HealthCare services.

To say the least, we are frustrated and disappointed by this development, and remain hopeful that modifications at the state level will allow resumption of Medicaid coverage by RMHMO in the near future. Every effort will be made to assist you, your office, and your patients in this time of temporary transition. If you have any questions, you may contact Greg Coren, RMHMO Manager of Provider Relations, at (970)244-7924 for further information.

Thank you for your ongoing support in these complex times.

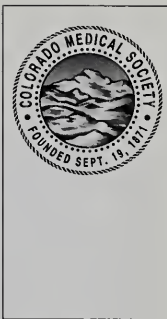
You're too busy practicing medicine to play politics

Every day you see the effects of health care reform on your practice. Every day you promise yourself that you will become more involved and help shape the future of medicine. But the truth is that sometimes you are just too busy.

Fortunately you have COMPAC. Legislators are becoming aware of and educated by organized medicine. However, the Campaign Reform Amendment and legislator turnover in both Houses in 1998 may dramatically affect the legislative advances made for you and your patients.

Join COMPAC today and become personally involved in the future of health care in Colorado. Then rest assured the voice of organized medicine will continue to be heard at the state legislature. For information call (303) 779-5455, ext. 2410 or 1-800-654-5653.





by Marjie Grazi Harbrecht, MD
Risk Management
Copic Insurance Company

Quality of Care: Breast Lumps and Lesions

Delay in diagnosis of breast cancer is one of the most frequent and costly grounds for malpractice litigation in Colorado. In a continuing effort to reduce the causes of these claims, Drs. George Thomasson and Robert Brittain of the Copic Risk Management Department proposed revision of the Participatory Risk Management Program (PRMP) Breast Carcinoma Guidelines first published in 1986.

The process consisted of two parts which were combined to form a basis for the new guideline development. First, establishing **The Breast Management Task Force** to determine baseline recommendations for the management of certain breast problems, including suggestions for maximum resolution periods. Second, conducting **A Breast Claim Review Study** to define key factors involved in previous claims. The study was a descriptive analysis, using evidence-based data from comprehensive reviews of Copic claims. Of **248 breast-related claims** opened since Copic's inception, the most common claim type was **delay in diagnosis of breast cancer (60%)** with over half of them (58%) requiring some indemnity and/or expense payment. From these, 66 claims were selected for the study. Though statistical analysis has not yet been completed, many of the study findings are consistent with similar investigations performed throughout the country. Below is a brief description of the most important findings.

- When looking at each patient's earliest first detect date, the most common presenting symptom

was a **"lump"** (56% of the time), with 44% of those accompanied by tenderness.

- The most common category leading to delays was **"provider management issues"** (49% - **Graph 1**) and included problems such as "underestimation of exam" and "inadequate plan after a negative or borderline mammogram/ultrasound." These primarily involved the failure to obtain a tissue biopsy despite the presence of a dominant mass. "Documentation problems" also occurred frequently.
- The average length of delay was **13.7 months, with the shortest delay being 3 months**. An interesting but unexplained finding was the higher than expected number of claims occurring between 3 to 6 months (**Graph 2**).
- **Obstetrician/Gynecologists, Family Practitioners and Radiologists** were the three specialists most frequently named in suits with total claims of 19, 18, and 17, respectively. **General Surgeons** were next with 7 total claims.
- The mean age at first detect was **41.5 years, with the youngest patient being 26.4 years**. The majority of patients were in the "30 to 39" and "40 to 49" year age groups, composing 73% of the claims (**Graph 3**).

Based on the study, it appears that those who most often sue for delays in diagnosis of breast cancer are younger than those typically expected to present with this disease

"Introduction to The Copic PRMP Guidelines for Breast Lumps and Lesions" — worth 2 ERS points. A seminar will be given at the CMS Annual Meeting on Friday, September 11th, at 4:30 p.m. For other seminar details, please refer to *Copiscope*.

(ages 61 to 65). Often, younger women presenting with a dominant mass are not fully evaluated due to a provider's low level of suspicion or reliance upon negative imaging studies. Inadequate documentation, system failures leading to unsuccessful follow up, and communication problems also contribute to these claims. **It is felt that by increasing awareness of these problem areas, the majority can be avoided through improved clinical management and administrative procedures.**

With this in mind, Copic has launched a "kick-off campaign" to disseminate the revised **Copic Participatory Risk Management Program (PRMP) Guidelines for Breast Lumps and Lesions** to their insured physicians involved with breast management. This will give physicians in these specialties (family practice, internal medicine, general surgery, gynecology, obstetrics, pathology, radiology, and radiation on-

cology) an opportunity to become familiar with the guidelines before they officially go into effect on **January 1, 1999**. As part of the campaign, an information packet will be mailed out which contains a copy of the guidelines; additional reference materials; and a **short postcard test** to confirm review of the guidelines (**completion worth 1 ERS point**). The guidelines will also be available on the Copic web site at <http://www.copic.com/guidance/br-gdln.htm>. In addition, physicians may attend a new ERS seminar — **"Introduction to The Copic PRMP Guidelines for Breast Lumps and Lesions"** — worth 2 ERS points.

While it is unknown how certain diagnostic delays affect clinical outcomes, it is evident that these delays can be devastating for both patients and providers in medical, legal, emotional and psychological terms. It is hoped that **The Copic PRMP Guidelines for Breast Lumps and Lesions** will serve as an effective instrument for providers, the goal of which is to promote consistency in managing breast problems, improve quality of care for female patients and thereby decrease the risk for malpractice litigation. In addition, work is currently underway to develop tools to enhance the effectiveness and ease of guideline use when managing patients with breast problems.

For further information regarding any of the issues discussed above, please contact Marjie Harbrecht, M.D. at 930-2579 or George Thomasson, M.D. at 930-0438.

NOTES:

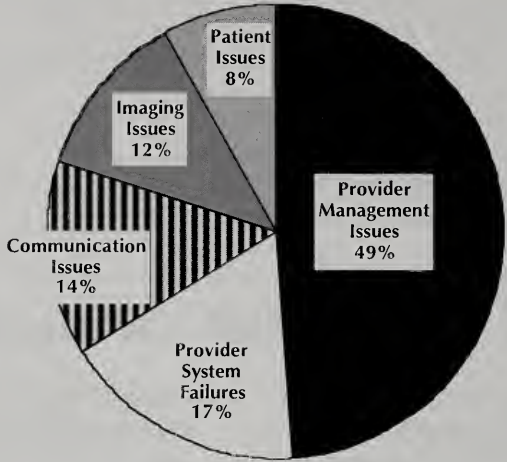
Graph 1 & 3: 66 "delay of diagnosis" claims closed between 1/1/87 and 4/2/97 with indemnity and/or expense paid.

Graph 2: A delay is defined as the time between the first detect date, when the healthcare community becomes aware that a patient has a breast problem, and the definitive diagnosis date, when the diagnosis is confirmed by tissue sample.

Graph 1-3: From the Copic Breast Claim Review Study, Marjie Grazi Harbrecht, M.D., Principal Investigator.

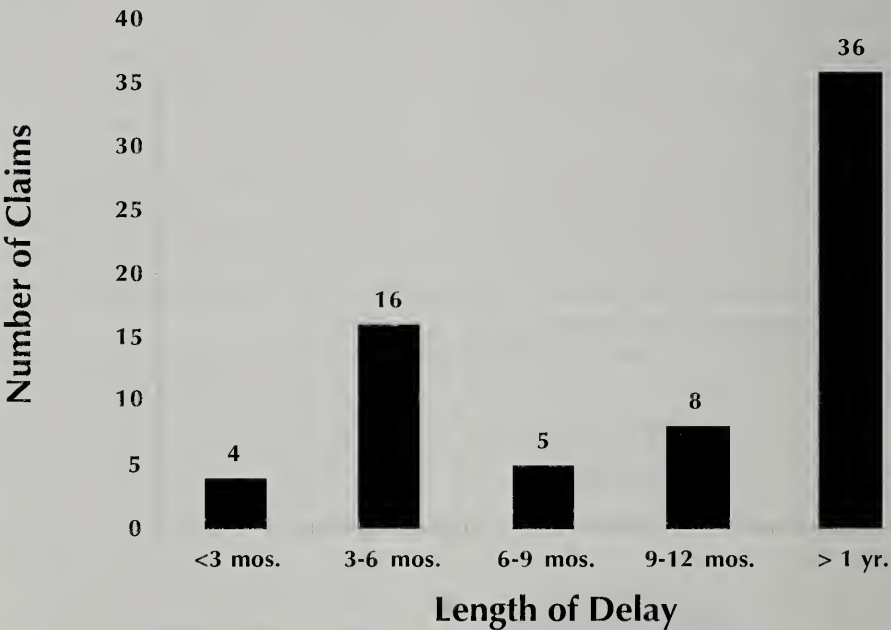
Categories Leading to Delays in Diagnosis of Breast Cancer

Graph 1



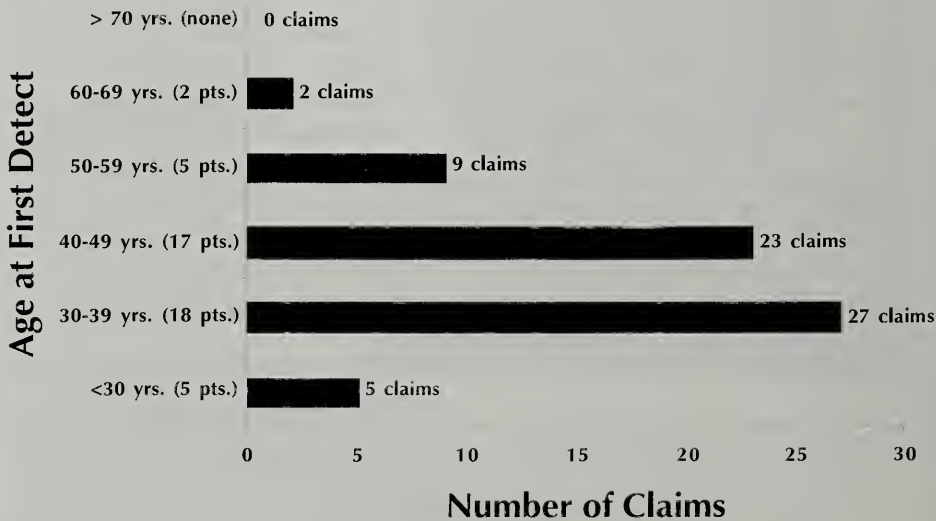
Graph 2

Number of Claims by Length of Delay

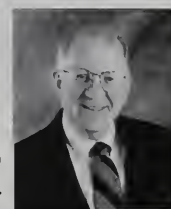


Graph 3

Number of Claims by Age at First Detect



by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Raising the Quality of Care Bar for Patients with Breast Lumps/Lesions

In this issue of *Colorado Medicine*, Marjie Grazi Harbrecht, M.D., a consultant to Copic's Risk Management department, has written an article to which I would like to call your attention. The article describes her research and work to produce revised Copic guidelines for the management of breast lumps and lesions. The goal of Copic's revised guidelines is to improve the quality of care for female patients by promoting consistency in the management of breast problems. With this quality improvement, it is further assumed that physicians' exposure for related malpractice litigation will decrease over time.

Dr. Harbrecht reviewed 66 delay of diagnosis claims at Copic that closed between 1/1/87 and 4/2/97 with indemnity and/or expense paid. Her research identified categories of problems that tend to occur with increased frequency in such cases. Among these are five areas where extra attention on the part of the physician can improve quality of care:

- **Provider management issues** – including underestimation of exam; inadequate plan after a negative test with a palpable mass; inadequate follow up after negative indeterminate mammogram; and incongruent exam
- **Provider system failures** – including follow up issues and inadequate follow up after an abnormal or borderline test result
- **Communication issues** – including physician-patient and physician-physician (for example, between the radiologist and the pathologist or between the primary care physician and the surgeon)
- **Imaging issues** – including various imaging technologies, the timing of their use, and the interpretation of their results
- **Patient issues** – including non-compliance and emotional/logistical factors

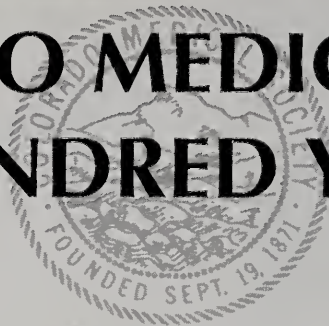
The multidisciplinary approach described in the guidelines represents a new direction for Copic's risk management efforts, bringing it more in line with the disease-state management programs we are seeing permeate the clinical care arena.

You've heard the old saying that "A chain is only as strong as its weakest link." This is particularly true when applied to clinical situations such as breast lumps and lesions. The quality of care, the patient's outcome, and the physician's risk of malpractice litigation all can be affected if the involved physicians fail to function as a coordinated unit.

The revised Copic guidelines will go into effect officially on January 1, 1999 for physicians in the specialties most closely associated with the diagnosis and management of breast lumps and lesions: family practice; internal medicine; general surgery; gynecology; obstetrics; pathology; radiology; and radiation oncology.

Work is currently underway in our Risk Management department on guidelines to address multidisciplinary management of colon cancer, chest pain, and prostate cancer. We will keep you informed of our progress both in *Colorado Medicine* and in *Copiscope*.

COLORADO MEDICAL SOCIETY ONE HUNDRED YEARS AGO



***IN 1898**

Colorado Medical Society, then 27 years old, had 511 members.

***IN 1998**

Colorado Medical Society, now 127 years old, has 5,260 members.

In 1898, Colorado had been a state only 22 years, and the economy and population base was chiefly agricultural and mineral, which meant that the majority of people were working with their hands in decidedly rural parts of the state.

In 1998, one hundred years later, a large percentage of Colorado's population still lives in rural areas, few of whom depend on agriculture or mining economies, but who still have one major factor in common.

Neither then nor now do 100% of Colorado's residents have necessary and proper medical treatment at hand; both then and now, they suffer a shortage of medical practitioners domiciled in these rural areas of the state.

What IS different about 1998 is that Colorado Medical Society has created
C.R.O.P. (Colorado Rural Outreach Program)

to fulfill the medical needs of the state's many rural areas, but your help is needed. CROP Foundation is anxious to have your help in this program to place physicians in the rural areas of Colorado.

***IN 1998**

there is no good reason why CMS can't help supply the physicians necessary to the rural populations through CROP (Colorado Rural Outreach Program) Foundation, if you will participate by contributing your time and knowledge.

Please...call or write for details on how you can help.

Contact the Foundation office at (303) 930-0407 or 1-800-654-5653, extension 2407



98

**1998 Annual Meeting of the Colorado Medical Society
September 11-13, 1998 • Sheraton Steamboat Resort**



**Study the “Black & White” issues of medicine
while enjoying the COLOR of
Steamboat Springs in September.**

Complete schedule and registration packet



Activities Available in Steamboat Springs during the CMS 1998 Annual Meeting

This information is provided by the Sheraton Steamboat Resort and the Steamboat Springs Chamber Resort Association published in the Steamboat Springs Summertime Activities Guide.

In Steamboat, you're surrounded by two million acres of National Forest and Wilderness Areas. There are over 150 mountain lakes, two major rivers, hundreds of creeks, dozens of mineral springs and two natural hot springs. Activities abound whether you're spending two hours or an entire week in Steamboat Springs. The activities will help you plan your days while taking advantage of many of the most popular things to see and do in beautiful Yampa Valley.

What to do in Steamboat Springs:

Walk, bike or skate the winding paved trail along the Yampa River Visit scenic Fish Creek Falls

Ride the Silver Bullet gondola up Mt. Werner to Thunderhead Park

Float high above mountain peaks in a hot-air balloon
1/2 and 1 hour tours \$80 to \$150 per person

Take a relaxing soak in the Strawberry Park Hot Springs
a 20 minute drive, 10 am to midnight, \$5 per person

Tour the beauty of the area on horseback,
daily 1 and 2 hour rides, \$30-35 per person

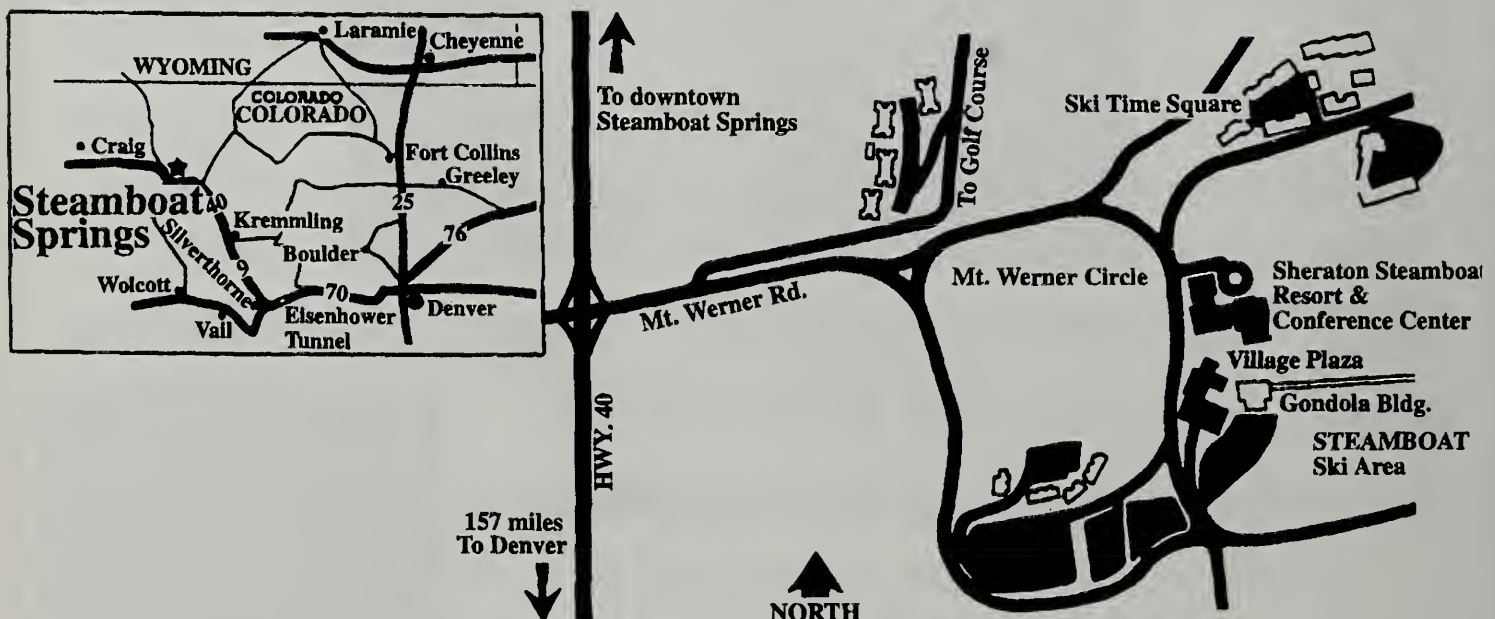
Learn the sport of fly fishing
\$50-85 per day, license and flies not included

Explore the ski mountain on a mountain bike
\$6 per hour, \$10 for 1/2 day and \$16 for full day

Enjoy a round of golf on a Robert Trent Jones II course
while taking in Steamboat's glorious climate

Most activities can be booked with Sheraton's Concierge staff in the hotel lobby, extension 1005. Prices subject to change.

Getting to Steamboat Springs



Annual Meeting Registration

1998 Annual Meeting of the Colorado Medical Society and the CMS Alliance
September 10-13, 1998, Sheraton Steamboat Conference Center and Resort

Name (please print) _____

Component Society _____ Name of Guest(s) _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservation deadline is August 12, 1998. Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders. (Note: To attend the President's Dinner Dance on Saturday, you must obtain your tickets before noon, Friday, Sept. 11 at the Reservation Desk.)

As a member, you and one guest are entitled to attend the complimentary events at no charge. Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complementary Events for Member & Guest

Please indicate below which functions you will attend. Additional guests are welcome, costs are indicated below.

Thursday, September 10

member

guest

6:00 pm Welcome Reception

☐☐

Friday, September 11

7:00 am Rural Physicians Forum Breakfast

☐

(members only)

8:00 am Alliance Breakfast

☐☐

5:30 pm Exhibitor Reception

☐☐

Saturday, September 12

additional guests

7:30 am Educational Program Breakfast

☐☐

_____ @ \$15/each _____

7:30 am Inspirational Breakfast

☐☐

_____ @ \$15/each _____

8:30 am Educational Program

☐☐

Noon AMA Forum Luncheon

☐☐

7:00 pm President's Dinner Dance

Meat dinner

☐☐

_____ @ \$50/each _____

Vegetarian Dinner

☐☐

_____ @ \$50/each _____

Vegan Dinner

☐☐

_____ @ \$50/each _____

8:30 pm Copic Dessert Reception

☐☐

Other Events:

Friday, September 11

Noon COMPAC/Alliance Luncheon

_____ @ \$20/each _____

Please make check payable to: **Colorado Medical Society**

Amount enclosed for additional guests and COMPAC Lunch \$ _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550); phone it to us (at 303-779-5455 or 1-800-654-5653); or fax it to us (at 303-771-8657).

Alice G. Gosfield, Esquire is a principal in the firm of Alice G. Gosfield and Associates, P.C., a specialized law practice restricted to health law and health care regula-



tions with a particular emphasis on managed care, utilization and quality management, medical staff issues, non-institutional reimbursement, peer

review, physician representation and fraud and abuse compliance.

Ms. Gosfield received her JD from the New York University School of Law and was editor of the *Journal of International Law and Politics*.

As founder of Telesis, Ltd., she was a consultant to hospitals, hospital associations, physicians and others on matters involving the interaction of clinical practice with regulatory systems including utilization management and quality assurance, the peer review organization (PRO) program, JCAHO accreditation, and implementation of medical staff development plans.

She has been a partner with Gosfield and Shay, Attorneys at Law; served as vice president, Health Policy Perspective, Inc.; and has been a staff attorney and consultant to the Health Law Project of the University of Pennsylvania.

Ms. Gosfield is currently Chair of the Board of the National Committee for Quality Assurance (NCQA), the managed care accrediting organization based in Washington, D.C.

She has presented at numerous national conferences and before many regional and state organizations. In addition to published articles and monographs, she has written a book, *Guide to Key Legal Issues in Managed Care Quality*, and is editor of the *Health Law Handbook*.

Ms. Gosfield will be our keynote speaker on Friday, September 11th and will also appear with E. Haavi Morreim, PhD on Saturday to discuss the gray areas of medical practice in dealing with managed care.

1998 Annual Meeting Schedule*

Sheraton Steamboat Conference Center and Resort
September 10-13, 1998

Thursday, September 10

8:00 am	CMS Office opens
9:00 am	18-hole Golf Tournament - Sheraton Course
1:00 - 2:00 pm	Finance Committee
2:00 - 5:00 pm	Copic Seminar
2:00 - 5:00 pm	Board of Directors
4:30 - 8:00 pm	Registration
6:00 - 7:30 pm	Welcome Reception
	Dinner on your own

Friday, September 11

7:00 am	CMS Office opens
7:00 am - 5:00 pm	Registration
7:00 - 7:45 am	Reference Committee Breakfast
7:00 - 7:45 am	New Delegate Orientation
7:00 - 7:45 am	Rural Physicians Forum
7:15 - 8:00 am	COMPAC Board
8:00 am - noon	Exhibits
7:45 - 8:00 am	Credentials Committee
8:00 - 8:30 am	Opening Session - HOD
8:00 - 9:30 am	Alliance Breakfast
8:30 - 12:15 pm	General Membership Meeting
9:30 am - noon	Alliance Membership Meeting
9:55 - 10:10 am	Refreshment break
12:20 - 1:45 pm	COMPAC/Alliance Luncheon
2:00 - 3:00 pm	Contracts Seminar, Greg Ruland
2:15 - 4:30 pm	Reference Committee
3:15 - 5:30 pm	Reference Committee
3:15 - 4:15 pm	FP/IM Physician A Copic Risk Management Seminar, George Thomasson, MD
3:15 - 4:15 pm	General Surgery/Urology/GYN A Copic Risk Management Seminar, Richert Quinn, MD
4:00 - 7:00 pm	Exhibits
4:30 - 5:30 pm	Guidelines for the Diagnosis of Breast Carcinoma, Marjie Harbrecht, MD
5:30 - 7:00 pm	Exhibitor Reception
6:30 - 8:00 pm	Women in Medicine
6:30 - 7:30 pm	Colorado Chapter, ACP/ASIM Annual Meeting
7:00 - 9:00 pm	Gone But Not Forgotten Dinner (by invitation)

1998 Annual Meeting Schedule*

Sheraton Steamboat Conference Center and Resort

(Continued from previous page.)

Saturday, September 12

7:00 am	CMS Office opens
7:00 - 11:00 am	Registration
7:00 - 11:00 am	Exhibits
7:30 - 8:20 am	Educational Program Breakfast
7:30 - 8:20 am	Inspirational Breakfast
8:30 am - noon	Educational Program
9:00 - 10:00 am	<i>Alliance Program - Frances Weaver</i>
noon - 1:30 pm	AMA Forum Lunch
5:00 - 6:00 pm	Primary Care Physician Caucus
5:30 - 6:15 pm	Meet the Candidates Reception
6:15 - 7:00 pm	Inaugural
7:00 - 10:30 pm	Presidents' Dinner/Dance
8:30 - 10:00 pm	Copic Dessert Reception

Sunday, September 13

6:30 am	Reference Committee Reports available
7:00 am	CMS Office opens
7:00 - 10:00 am	Registration
7:00 - 8:30 am	Component Caucuses
	Arapahoe
	Aurora-Adams
	Boulder
	Clear Creek Valley
	Denver
	El Paso
	Larimer/Weld
	Pueblo/Western Slope
	Eastern Plains
8:15 - 8:30 am	Credentials Committee
8:30 - noon	Closing Session HOD
Noon/following HOD	Reorganizational Board

Dress for Annual Meeting

Thursday Evening	casual, black & white attire
Friday	casual
Saturday Morning	casual
Saturday Evening	Black & White Ball - Dressy business attire or tuxedo/cocktail dress optional
Sunday	casual

* NOTE

Times are subject to change. You will receive a final schedule at registration.

E. Haavi Morreim, PhD, professor in the Department of Human Values and Ethics, College of Medicine, University of Tennessee, will keynote the 128th Annual Meeting of the CMS House of Delegates at the Sheraton Steamboat Springs Resort and Conference Center. Dr. Morreim was also the key-



noter at the CMS President-elect's Planning Conference at Vail in May and was extremely well received. She is an expert on medical ethics. Her address at Steamboat Springs will be concerning the gray areas of medical practice in dealing with managed care organizations.

Prior to accepting her position with the University of Tennessee in 1984, she was at the University of Virginia School of Medicine. She was named a full professor at the University of Tennessee in 1993. Dr. Morreim is the author of numerous articles and book chapters as well as *Balancing Act: The New Medical Ethics of Medicine's New Economics* published in 1991, republished in paperback in 1995.

Dr. Morreim received her PhD in philosophy in 1980 from the University of Virginia. She is a member of the American Society for Bioethics and Humanities, the American Society of Law, Medicine & Ethics, the Hastings Center and the National Health Lawyers Association.

Dr. Morreim will be recognized in the 53rd edition of *Who's Who in America* (1999), and in the 20th edition of *Who's Who of American Women 1997-98*, forthcoming. She is a member of Phi Beta Kappa.

CMS Annual Meeting Golf Tournament

Sheraton Steamboat Golf Club
Thursday, September 10, 1998
Entry Form

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While in Steamboat I will be staying at _____

I will be attending the meeting in the capacity of:

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Please reserve a set of ☐ Left handed ☐ Right handed clubs for me.
I will pay the \$25 rental fee on site.

If you would like to play, please return this entry form as soon as possible because space is limited. CMS has reserved tee time, starting at 9:00 am. for only eight foursomes. Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament reservation, entry form and advance payment of \$95 must be received no later than August 21, 1998. Cancellations received after August 21, 1998 are refundable subject to ability of Sheraton Steamboat Golf Club to "resell" vacated tee time.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at 970-879-1391.

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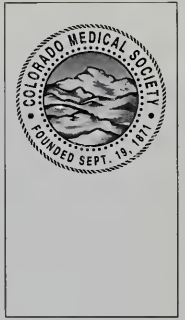


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Editor's Note: The candidates have been invited to state their reasons for running for president-elect. They are printed here as given to **Colorado Medicine**.

Jack L. Berry, MD

Jack Berry, a Family Physician from Wray, Colorado, would like to make the membership of the Colorado Medical Society aware he is a candidate for President-Elect of CMS and seeks your support. It has been many years since a genuinely rural physician has served as President of CMS, but I enjoy the unique position of having the time available to make the CMS presidency my only job.

Twenty-seven years of practice in predominately rural but urban environments have given me a broad experience in the academic and business aspects of medicine. I bring to the table 25 years of work in organized medicine at the county and state levels. For the last five years, I have been a member of the Board of Directors of CMS, the last year on its executive committee. I served 6 years on the Board of the Colorado Foundation for Medical Care, the last year as its president. On many occasions I have represented these and other organization in legislative arenas, meeting with national and state representatives and testifying before committees on various medical issues.

Physicians in all specialties have come to understand the need for physicians to work together to the best interest of their patients. Interspecialty conflicts and politics have disrupted and fragmented access to care. My most effective leadership skill has been enabling physicians of all specialties in their efforts to work together, presenting a common voice of advocacy for themselves and their patients.

Improving physician unity while addressing the many difficult issues confronting the physician community will be the focus of my presidency. When we look past the politics of interspecialty rivalry and place our patients and their interests as the first priority, we can achieve the goals of professionalism and social responsibility we physicians have always held dear. With your support and that of your delegates, I can work toward these goals as President-Elect of CMS.



Richard Allen, MD

I am honored to have been nominated for the office of president-elect of CMS, and would like to thank those who have been so supportive and confident in my abilities. It has been interesting and challenging chairing the Council on Legislation and working closely with the CMS staff and leadership over the past few years. I am proud that we have been proactive on health care issues and concerns that affect both our patients and the physicians of our state.

Over the years I have learned the importance of being sensitive to the views of all physicians, whether primary care or specialists, urban or rural, solo practice or multi-group. I know it is important to be a good listener and experience has taught me to compromise and build consensus for the greater good. It is imperative to elect a practicing physician who understands all of these points of view and has a background of proven performance.

We have been fortunate to have had a succession of excellent leadership in Colorado medicine. I look forward to continuing to support patient protections and their ability to access their physicians. The continuity of the patient-physician relationship must prevail. I feel that I have the time, energy, and proven track record of leadership and experience to take the Colorado Medical Society into the next millennium. I look forward to the opportunity to represent you.

Richard Allen, M.D.



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Christopher J. Unrein, DO
Chairman
Council on Legislation

Colorado Medical Society opposes legalization of "medicinal use" of marijuana

While the Colorado Medical Society believes that physicians must ensure that patients are provided optimal treatment for pain, the Colorado Medical Society opposes the ballot initiative which calls for:

"AN AMENDMENT TO THE CONSTITUTION OF THE STATE OF COLORADO AMENDING ARTICLE XVIII, ADDING A NEW SECTION TO READ:

Section 14. Medical use of marijuana for persons suffering from debilitating medical conditions.

Section 14 (1) As used in this section, these terms are defined as follows:

(a) "Debilitating medical condition" means:

(I) Cancer, glaucoma, positive status for human immunodeficiency virus, or acquired immune deficiency syndrome, or treatment for such conditions;"

Under this proposal, "**Medical use**" takes on a meaning all its own, relative to accepted "medical practice."

Section 14 (I) (b) "Medical Use" means the acquisition, possession, production, use, or transportation of marijuana or paraphernalia related to the administration of such marijuana to address the symptoms or effects of a patient's debilitating medical condition, which may be authorized only after a diagnosis of the patient's debilitating medical condition by a physician or physicians, as provided by this section.

The high quality practice of medicine should not be determined by the popular vote. Safe and effective medical modalities are determined by scientific and reproducible research. "*Medicinal marijuana*" has safe and effective alternatives. Physicians are professionally obliged to educate themselves and their patients about these alternatives.

On Friday, July 31, 1998, the CMS Board of Directors, voted unanimously to oppose the ballot initiative. A resolution will be before the House of Delegates at the Annual meeting in September.

Here are some facts about the "medical use of marijuana":

There is a 1998 ballot initiative seeking to legalize the medicinal use of marijuana in the state of Colorado.

Smoked marijuana has not been approved by the FDA to treat any disease or condition.

Sufficient studies of smoked marijuana have not been submitted to permit the FDA to determine if the potential benefits of smoking marijuana for specific indications outweigh the known risks associated with the drug.

FDA approved drugs whose active ingredients are dronabinol or delta-9-tetrahydrocannabinol (THC) may be legally prescribed by physicians.

The American Medical Association (AMA) Council on Scientific Affairs (CSA), after extensive study, concluded:

(Continued on following page)

Facts about the "medical use of marijuana": *(Continued from preceding page)*

"Some of the apparently disparate findings on the medical utility of smoked marijuana may be explained by the use of crude plants of variable potency and the inclusion of both experienced and naïve smokers in the study. The latter feature affects the smoking behavior and efficiency of drug delivery by inhalation. Depending on the condition, research questions to be addressed on smoked marijuana include determining (1) whether it is efficacious; (2) how it compares to Dronabinol®; (3) whether it is beneficial when used in combination with standard therapies or in patients refractory to standard medications; and (4) whether it has benefit primarily in marijuana-experienced smokers. Additional concerns in conducting research on smoked marijuana are the lack of data on its safety in older patients and in those with serious diseases, especially involving the cardiovascular system. A smoke-free inhaled delivery system for marijuana or THC would be preferred.

THC is moderately effective in the treatment of AIDS wasting, but its long duration of action and intensity of side effects preclude routine use. The ability of patients who smoke marijuana to titrate their dosage according to need and the lack of highly effective, inexpensive options to treat this debilitating disease create the conditions warranting a formal clinical trial of smoked marijuana as an appetite stimulant in patients with AIDS wasting syndrome.

THC and smoked marijuana are considerably less effective than currently available therapies to treat acute nausea and vomiting caused by chemotherapy, although certain patients still do not respond adequately to conventional therapy. Research involving these substances should focus on their possible use in treating delayed nausea and vomiting, and their adjunctive use in patients who respond inadequately to 5-HT₃ antagonists. The use of an inhaled substance has the potential for benefit in ambulatory patients who are experiencing the onset of nausea, which precludes administration of an oral dosage form.

Very limited controlled evidence suggests cannabinoids can modify the symptoms of individual patients with spasticity or dystonia. Considerably more research is required to identify patients who may benefit from THC or smoked marijuana, and to establish whether responses are primarily subjective in nature. A therapeutic trial of smoked marijuana or THC may be warranted in patients with spasticity who do not derive adequate benefit from available oral medications, prior to their considering intrathecal baclofen therapy or neuroablative procedures. Controlled evidence does not support the view that THC or smoked marijuana offer clinically effective analgesia without causing significant adverse events when used alone. Preclinical evidence suggests that cannabinoids can potentiate opioid analgesia and that cannabinoids may be effective in animal models of neuropathic pain. Further research into the use of cannabinoids in neuropathic pain is warranted.

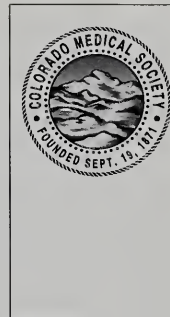
Neither smoked marijuana nor THC are viable approaches in the treatment of glaucoma, but research on their mechanism of action may be important in developing new agents that act in an additive or synergistic manner with currently available therapies."

We strongly urge physicians to actively oppose this initiative and to work diligently to educate all patients about the lack of scientific evidence demonstrating the efficacy of "medical use of marijuana."



Attorney General Candidates to address COMPAC/Alliance Luncheon

Ken Salazer (D) and John Suthers (R), candidates for the office of State Attorney General have been invited to participate in a dialogue at the COMPAC/CMSA Luncheon scheduled for Friday, September 11th during the 1998 CMS Annual Meeting. This program will be moderated by Dr. Bob Sawyer and promises to be a lively and educational experience. Tickets for the luncheon are \$20 and should be purchased prior to the meeting. Space is limited.



by Gerald N. Weiss, M.D.
Fort Collins, CO

To the Editor:

After reading Dr. M. M. Hine's *Guest Editorial* in the April, 1998 issue of *Colorado Medicine*, I was amazed by the statement concerning marijuana that: "It is not physically addicting, and not one case of human death due to its use has been credibly documented." Hasn't Dr. Hines been reading the reports? Do we read the same current literature with different conclusions? To wit, according to the Drug Enforcement Administration (at Web site: <http://www.usdoj.gov/dea/pubs/sayit/myths.htm>) and also the Hearing Before the Committee on the Judiciary United States Senate, December 2, 1996, "Prescription for Addiction? The Arizona and California Medical Drug Use Initiatives" S.HRG.104-874), these conclusions were drawn:

- The facts available in over 10,000 scientific studies have shown marijuana to be a harmful **addictive*** drug;
- Marijuana **enhances trauma** on our highways, e.g., a Maryland study showed 1/3 of drivers had smoked marijuana within 24 hours of the crash.

a Boston study revealed 16% of drivers "most responsible" for a **fatal** accident used marijuana prior to the occurrence; the National Transportation Safety Board found in 182 **fatal** crashes that 13% of the drivers tested positive for marijuana.

* Emphasis added by author

It is a common situation today when we read stories that have headlines which reveal only partial truths that it does get one's attention. **Let's get some facts straight**, however, before so many die because of misinformation through half-truths and incomplete data is submitted to the public. This has led to faulty judgements and miscast ballots! There is not one medical study that demonstrates marijuana has any medical value. The FDA, DEA and the U. S. Public health Services have rejected smoking crude marijuana as a medicine. Delta-9-THC extracted from *Cannabis sativa L* (marijuana) is available to physicians for prescription as Marinol tablets which are accurately calibrated.

Smoking illegally available material **is not!** Incidentally, no medicine prescribed today is **smoked!!**

- Marijuana is an unstable mixture of more than 425 chemicals that convert to thousands when smoked. Many are toxic, psychoactive chemicals largely unstudied and appear in uncontrolled strengths.
- Currently, marijuana is up to 25 times more potent than in the 1960s, making it more likely to be addictive;
- Chronic use can produce sinusitis, pharyngitis, bronchitis, emphysema;
- A marijuana cigarette has four times more tar than a tobacco cigarette, thus making them more carcinogenic per unit;
- Compromises brain function (hostility and increased aggressiveness, general apathy,

"Let's get some facts straight, however, before so many die. . ."

memory loss, verbal reasoning, depression, etc.);

- Alters unfavorably the immune system and hormonal responses to stress, e.g., HIV-positive marijuana smokers progress to full-blown AIDS twice as fast as the non-smokers plus having an increased risk of bacterial pneumonia;
- Is a "gateway" drug leading to use of more powerful, dangerous ones;
- Cause of Death for those dying in vehicular accidents where marijuana is involved is **not listed as the cause** but rather under "Contributory Causes" (according to a Detective with the Larimer County Drug Task Force).
- Finally, in my opinion, the emotional, family and community discord created by the smoking of marijuana far outweighs its individual selfish use by individuals so inclined.

(Continued)

GUEST EDITORIAL RESPONSE

(Continued from preceding page)

According to Mr. William Pierson, Director of Communications at the Colorado Medical Society, **not one** physician has questioned Dr. Hines' statements!! With a degree in Master of Public Health, one assumes that he would be more knowledgeable concerning death certificates' limitations. As an Occupational Medicine physician, he is in a position to recognize the hazards of marijuana in the workplace. It's problem enough with the freedom of use of tobacco and alcohol in spite of warnings. We have some degree of legal oversight with protection against alcoholic DUI drivers, whereas with marijuana we have no such equivalent tests to implement a similar degree of regulation.

The public relies on physicians for health **prophylaxis** as well as care. It seems incumbent upon all of us, especially those in public health and occupational medicine, to send out the right signals to the public. We physicians must be acutely aware of our practice and art by contributing and acting as a positive creative force in disseminating reliable, factual information on so vital a topic as marijuana. A wealth of valuable **information can be obtained** by requesting publications from the **National Clearing House for Alcohol and Drug Information at 1-800-729-6686**. We physicians owe it to our families, our patients, our communities and ourselves to know the facts and present them without preferential biases.

Respectfully submitted,
Gerald N. Weiss, M.D.
Fort Collins, CO



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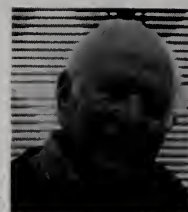
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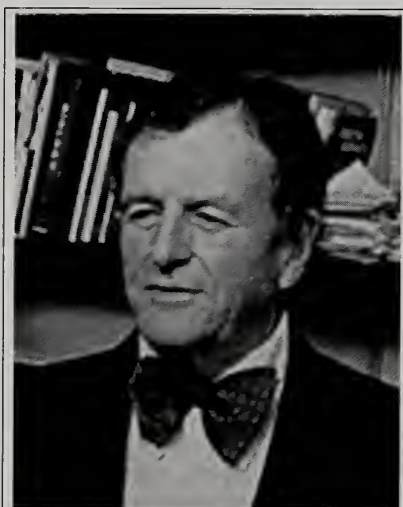


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by John L. Lightburn, MD
Historian, Colorado Medical Society

"He flew with the eagles"



Henry Swan, MD

In the spring of 1953, when I was Medical Director of Mount Airy Hospital, I received a call from Dr. Henry Swan, chairman of the Department of Surgery at the University of Colorado. He wanted to know if we had some fever cabinets in our storage area. He had recalled that psychiatry used to treat tertiary syphilis with artificial fever (before the days of penicillin). Yes, we had one. "I'll be right over." He was looking for an effective means of raising the temperature of patients who had undergone hypothermia during open heart surgery. That was my introduction to the brilliant and talented Henry Swan.

Henry Swan, II, was born on May 27, 1913. His father, Henry Swan, was prominent in financial circles on Denver's Seventeenth Street and was delighted with his son. He was an outstanding student at Phillips Exeter Academy, cum laude, 1931. At Williams College, he majored in the humanities with only the bare minimum pre-med requirements. He was graduated magna cum laude in 1935. He entered the class of 1939 at Harvard Medical School, often called the "elite class" because it produced six professors and chairmen of surgery and innumerable professors in other specialties. Henry became a member of A.O.A. in his junior year and was valedictorian in this famous class. After a year of Pathology Residency at Colorado General Hospital (1939-1940), he returned to Boston to start his Surgical Residency at Boston's Children's Hospital and the Peter Bent Brigham Hospital. For the last eight months of his second year, he was the only surgical resident at Children's; his fellow residents had been called into the armed services. This gave him an extraordinary experience in pediatric surgery and an opportunity to work with Dr. Robert Gross, pioneer cardiac surgeon. But the nation's need for surgeons in the Army was too urgent and Henry volunteered to join the Army, in which he soon became Chief of a surgical team in the 5th Surgical Group. His group landed on D+1 of the Normandy invasion on Utah Beach and followed the front all the way to the Elbe river. Among the many trauma cases he treated was a soldier with shrapnel wound

to the popliteal artery. Standard operating procedure for such a wound was ligation resulting in deficient circulation to the lower extremity. But Swan decided to try to repair the artery with a suture anastomosis. This was successful and the soldier did not lose his leg. So early in his career his experiences were directing him toward cardiovascular surgery.

When he returned to Denver after the war, he found Ward Darley creating quite a stir as the new Dean of the University of Colorado medical school. Darley had a vision of a school with a full-time faculty in the Department of Surgery (1946). Assistant Professor Henry Swan received a grand total of \$5,200 for his annual salary. One of his first moves was to establish a research laboratory for the department. He "borrowed" some storage space from the pathology department, applied for and received a grant from the U. S. Public Health Service (predecessor to N.I.H.) to study the possibility of a shunt between the auricles in the treatment of mitral stenosis. This small grant of \$3,600 was the beginning of the research activities of the department and the Halstead Animal Research Laboratories. Here he began his studies in arterial reconstruction, storage and grafting. In 1949, after laboratory testing of graft preservation in Ringer's lactate solution, he inserted an 8cm segment of a homograft into the descending aorta of a young boy who had severe coarctation of the aorta. The boy recovered and Swan reported it in the *Archives of Surgery* in 1950. His Chairman, Dr. Jack

Foster, was grooming the charismatic young surgeon for the chairmanship. After four years as an assistant professor, he was elevated to the chair on July 1, 1950. He was the first full-time Surgical Chairman and the youngest (37) at the University of Colorado School of Medicine. He took over a little-known department, totally lacking in laboratory facilities, and with a total department budget that was less than a salary of a current chief resident in surgery. What vision he must have had to do so much with such a modest beginning!

At Boston Children's Hospital, Dr. Swan had experienced the frustration of trying to help young children with congenital heart disease. He was touched by these tragic cases and was determined to find a way to surgically correct those heart malformations. In the spring of 1950, he had flown back to a meeting of the American Surgical Association at Greenbriar, West Virginia. He could have played golf but he attended a presentation of a paper by Wilferd Bigelow who had experimented with a series of dogs in which he had lowered the body temperature to 25 degrees centigrade under general anesthesia, opened the chest, clamped the vena cava for 15 minutes and then closed the chest and restored the animal to normal temperature. There was a mortality rate of 85%, mostly due to ventricular fibrillation. The paper did not create much of a stir at the meeting, but as Dr. Swan was flying home, he suddenly understood the message of the paper: 15% of the dogs had lived. For 15 minutes there had been no blood flow to the body or brain and yet some of those dogs were still alive. This brought to mind many questions which might be answered in the Halstead Laboratory. From June, 1950, for two years, he asked the third year surgical residents to spend all their time in the laboratory studying the effects of hypothermia and clamping the vena cava on over 300 dogs. The prob-

lems associated with such a procedure had to be understood and solved before entering the clinical arena. Swan had invaluable help from his dedicated house staff, one of whom was third year resident E. B. "Ebe" Liddle. Ebe had left his residency position in Jersey City to be in the training program with Dr. Swan. He was working full time in the Halstead Research Laboratory when, in January, 1953, Swan did his first open heart surgery on a patient with an atrial septal defect. After watching the procedure, "Ebe" checked in on the patient and found the patient in hypovolemic shock. He rushed to find Swan who immediately saw the patient and, agreeing with Ebe's diagnosis, started an intra-arterial transfusion. The patient survived.

You can imagine the enormous challenge this presented to Dr. Swan and his collaborators. There were many on the faculty who were involved with this pioneering effort. Dr. Robert Virtue, Professor of Anesthesiology; Dr. Gilbert Blount, Professor of Medicine and chief of the cardiology division; Dr. Arthur Prevedel and the many hard working house staff such as W. Gerald Rainer, Ebe Liddle, Larry Kircher and George Lindeman. The whole procedure was long and arduous. After an extensive diagnostic and medical workup, the patients were anesthetized with ether, immersed in a bathtub of ice cold water until the body temperature was reduced to 29 to 32 degrees centigrade, the heart rate decreased to 20-30 per minute, at which point the chest was opened and the heart could be clamped off and Swan had 4 to 6 minutes to open the heart, repair the defect, close the heart, remove the clamps and close the chest. You can imagine the stress experienced by the whole operating team. By June, 1953, they had completed 13 surgeries in which congenital defects were corrected by open heart surgery with a mortality of just one patient. In August of that same year, Swan and his team published a report of these thirteen cases in the *Journal of the American Medical*

Association (JAMA), the first successful series of open heart procedures. Swan attributed his success and low mortality rate (e.g., no deaths in the first 69 patients who underwent surgery on the pulmonary valve) to their extensive laboratory experience with over 400 dogs.

The Department of Surgery immediately became world famous. A steady stream of patients to be treated and surgeons to learn came to old Colorado General Hospital. To spread the word, Swan and Virtue along with cardiologist Gilbert Blount traveled around South America teaching and operating. Most of the time they traveled in Swan's private plane with Swan as the pilot. It is said that flying with Swan was sometimes terrifying and always exciting. Being with Swan was never dull. He shared his dreams and plans as he piloted the plane to the next stop.

During his eleven years as Chairman, Dr. Swan performed over 800 open heart surgeries, each one demanding an exhausting procedure. The mortality rate with the first 400 was 12% and about 6% with the last 100 cases. After the first seven years, the heart-lung perfusion machine supplemented the hypothermia and gave the surgeon more time to do his work. Swan also authored 250 papers. His department thrived under his leadership. He was a superb surgeon, but in addition had an unquenchable thirst for knowledge in all fields. For example, he was fascinated by the process of hypothermia. After he retired from the University he continued his research into hypothermia with various animals at Colorado State University (CSU). Brilliant as he was, his flamboyant and irrepressible style did not fit with the usual scholarly demeanor that characterized some of his faculty colleagues. His peripatetic travels to numerous professional meetings in his private plane resulted in a somewhat blemished reputation as a pilot. He survived four separate accidents. He returned from one flying trip with two injured legs which confined him to a wheelchair. This did not interrupt his surgical

schedule, however. He brought a hoist into the surgery which raised him up to the operating table.

Though he had some detractors, they were far outnumbered by many loyal friends both in and out of the profession. Dr. Florence Sabin, the wonderful woman who brought the state's public health system into the 20th Century, was very fond of him and visited with him often. Earlier in her career she had been on the faculty of Johns Hopkins Medical School where she was a very good friend of Dr. William Stewart Halstead, prestigious Chairman of the department of Surgery at Hopkins. As a demonstration of esteem and affection, he had given her an autographed photographic portrait of himself. She autographed this portrait dedicating it to Dr. Swan. Some years later, Henry autographed this same portrait and gave it to W. Gerald Rainer, MD, who later became President of the Colorado Medical Society. Dr. Ben Eiseman, in a tribute to Swan, wrote: "We were few, worked endlessly, were paid a salary that would be spurned today... — but what a joy it was to work in that exciting, intellectual environment... that was the real mark of his leadership... His memory is important to those who subsequently profited by his leadership and innovative skills in the University of Colorado Medical School Department of Surgery. It is on the shoulders of men like Dr. Swan that practicing vascular surgeons now stand... Perhaps each of us can profit by emulating his example."

The real mark of this man's breadth and depth were his many interests and friends outside the field of surgery. He loved his farm out in Jefferson County. He and his wife, Geri, developed and grew special tomatoes and other vegetables and served the products of their farm at parties in their home where they served vintage wines from his fine cellar. He fished and hunted with the same enthusiasm and skill that he did his surgery. In addition to Ben Eiseman's tribute to Henry at the

time of his death in 1996, his friend Gene Amole wrote a tribute to "Henry Swan's Adventurous Heart" in his newspaper column on June 16, 1996. Here are some excerpts from that column:

- "When I think of Hank, it's always as the adventurer. The meaning of life for him was simply to live it, and he did with gusto and imagination. He was interested in everything. He called me late one night to discuss 16th Century dance music with original instruments."

- "It was exciting just to be around him. He was not my doctor but my friend. He had brief flirtations with private practice, but that kind of life was not for him... Hank once opened a little office at 3rd and Josephine Streets, but I don't think he ever saw any patients there. It was just a place for him to sit, to read, to putter and to plan his next foray into the unknown."

- "I stopped by to meet him for lunch one day and found him looking out the window through a sextant... He wanted to build a sailing ship and cross the Atlantic. The ship was built in Scotland, but he couldn't get a crew to go with him."

- "He organized an African safari to study the lung-fish. Hank thought they might hold the secret of suspended animation because they could survive months of drought caked in mud. He even brought some home and kept them in his bathtub."

- "What a great companion he was! He loved to hunt, fish and cook. He was fond of hosting black tie dinners at which he prepared and served food he had that he had caught, shot, strangled or cultivated in his garden."

- "My lasting memory of him was a frigid morning years ago in a duck blind... His expensive Browning semiautomatic shot gun was frozen. My cheap J. C. Higgins pump worked like a champ... when we spotted three Canada honkers flying toward us... Hank said he would coach me... 'Lead them a little more... Easy now'

... but my finger went limp on the trigger... 'Shoot, Gene! Now!... I couldn't do it... as the honkers disappeared into the mist, we both started to laugh... Then we slogged back to the old railroad 'reefer' we used as a hunting shack and Hank rassled up strong coffee, flapjacks and bacon."

- "How poignant it was that I had a letter from Hank just a couple of weeks ago, and in it he recalled this same incident. I am pleased we remembered each other that way."

References:

Shikes, R.H. and Claman, H.N. *The University of Colorado School of Medicine, A Centennial History, 1883-1983*

Amole, Gene, in his column of *The Rocky Mountain News*, 6/16/96

Liddle, E.B. and Rainer, W.G. Personal communications.



by Suzi Shevell, Program Manager
Colorado Medical Society

The Colorado Medical Society Foundation (CMSF) is reaping the benefits of efforts put forth to make the vision for CROP become a reality. Gifts and pledges are coming in and our volunteer force is growing. Some very significant players in the health care, corporate and philanthropic arenas have made generous contributions to CROP and we've asked representatives from a couple of these organizations to share their reasons for choosing to support this important project.

Copic Medical Foundation

The Copic Medical Foundation made a gift of \$75,000 to the CMSF in support of CROP. Dr. Jerry Buckley, Chairman of the Board, explains that Copic is in the business of addressing the needs of physicians in Colorado. When the CMSF made a proposal to the Copic Medical Foundation to support a program which would help rural medically underserved communities recruit and retain physicians by offering loan repayment in exchange for a minimum term of service, Copic Medical Foundation saw a way to assist while remaining true to their mission. Dr. Buckley believes CROP can also address a physician maldistribution problem in Colorado by helping doctors relocate to rural areas of the state where their services are badly needed. National and state data on physician distribution was helpful in the decision making process. The data indicates that close to 90% of physicians in Colorado practice in metro areas. Additionally the data shows that between 1994 and 1996, the

number of rural counties without a physician increased.

In his prior practice life, Dr. Buckley remembers a time when he and his partners at the Colorado Allergy and Asthma Clinic were doing telephone consultations with a family physician in Haxtun on a very regular basis. It was difficult because of family, work and financial reasons for patients to go to Denver for the care they needed. Dr. Buckley and his partners made arrangements with the hospital in Haxtun to visit patients on a regular basis to provide necessary care. This was a partnership between the hospital, the local physician and the community that benefited the people of Haxtun and surrounding areas. Dr. Buckley's personal understanding of the issues and circumstances facing a rural community in need of services remains with him today and contributed to his support of the Copic Medical Foundation's decision to support the Colorado Rural Outreach Program.

HealthONE

"This is an organized medicine initiative that could really work and looks like it will be successful" says K. Mason Howard, MD, a Trustee of HealthONE. HealthONE sees a physician distribution problem in Colorado that they hope to be able to impact. HealthONE believes the concept of CROP and vision for achieving its goals is realistic and can be carried out successfully. When asked what HealthONE would like to see CROP accomplish, in addition to the goals set forth in the program plan, Dr. Howard said

he believes there is a need for more training of family physicians to practice rural medicine as the type of medicine delivered in rural areas may require a different knowledge and skill set than traditional training offered in family medicine residency programs.

Dr. Howard recalls, as the original Chairman of Copic, while traveling the state talking to potential insureds, seeing rural physicians experiencing burnout and overload as there was no one available to cover their practices when they needed to take time off for personal or professional reasons. This is a scenario in which CROP could make a significant impact.

We offer sincere THANKS and APPRECIATION to the following individuals and organizations for their support of the Colorado Rural Outreach Program... without their generosity, the program would not exist.

UNDERWRITER'S CIRCLE

Gold	\$250,000 and above
Silver	\$100,000 – 249,999
Bronze	\$50,000 – 99,000 Copic Medical Foundation HealthONE

LIFE FOUNDER

Gold	\$25,000 – 49,999
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Bronze \$5,000 – 9,999	The Anschutz Family Foundation Colorado Health Professions Panel Patrick A. Grant Mesa County Medical Society US Bank
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CMS member Wins the EIEIO Award!

by Suzi Shevell, Program Manager
Division of Health Care Policy

In M. Scott Peck's book, *The Road Less Traveled*, he says "if you love something you spend time with it". Steve Brethauer, a personal friend of Dr. Jack Berry, assimilated this concept and Dr. Berry's own way of life when presenting him with the Colorado Rural Health



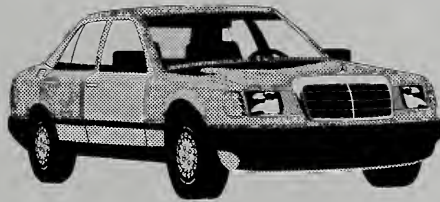
Jack L. Berry, MD

Center's EIEIO Award. This award recognizes an individual who has made outstanding contributions to health in rural Colorado. That is most certainly Jack

Berry, MD. The award was presented at the Colorado Rural Health Center's Annual Rural Health Conference in Sterling on June 25th.

Mr. Brethauer told attendees about Dr. Berry's passion for taking care of rural folks and speaking on behalf of people who are not often heard. One of Dr. Berry's most impacting personal accomplishments for the people of Wray and Colorado is his development and direction of the Rural Family Practice Residency in Wray. In his nomination materials, it was stated that "Jack has dedicated his entire working life to the care of people in rural communities". Dr. Berry has personafied this dedication by traveling the length and breadth of the state on behalf of the needs of rural Colorado residents for greater access to the health care system. Dr. Berry has been a spokesperson for the CMS rural health program in its various forms for the past five years. He was a member of the Health Affairs Council and then served as chairman of the CMS Rural Health Task Force. He has also been a strong advocate for the rural family practice residency program. To this we say, thanks and congratulations to a fine country doctor.

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Colorado Medical Society



Reimbursement for Off-Label Use of Drugs

by Edie Register, Director
CMS Division of Health Care Finance

Many health insurers limit access to "off-label" uses of approved drugs

The Food and Drug Administration (FDA) allows drugs to be marketed only for their approved indications. After a drug is approved for one purpose, however, physicians legally may prescribe the drug for other purposes or diseases. This is called "off-label" use of drugs or use for "unlabeled indications." The US General Accounting Office estimates that about 56 percent of cancer patients received an "off-label" drug.

Many health insurers limit access to "off-label" uses of approved drugs by refusing to provide financial reimbursement for them. This presents an undue financial and emotional strain on cancer patients and may result in unnecessary suffering and even death if the treatment is denied.

Requiring FDA approval for every new indication may take more than five years each and millions of dollars on behalf of the drug manufacturers. In addition, once the patent for a drug expires, there is little incentive for the drug company to seek FDA approval for a new indication because the company may not be able to recoup the investment in research without exclusive manufacturing and marketing capability.

The American Cancer Society concurs with the FDA position that "off-label" use of approved cancer drugs may be an appropriate treatment regimen for many patients, as determined by medical experts and prescribed in accepted medical compendia and journals. The American Cancer Society supports legislative and regulatory initiatives to require health insurance companies, Medicaid, Medicare, and public employee

benefits plans to provide reimbursement for "off-label" use of approved cancer drugs, provided that such drugs have been recognized for treatment of the specific types of cancer in established medical reference compendia.

According to the Association of Community Cancer Centers (ACCC), as of July 17, 1997, 28 states had laws for private insurers to cover "off-label" use of drugs:

Alabama*
Arkansas
California*
Connecticut
Florida
Georgia
Hawaii
Illinois
Indiana
Louisiana
Maryland*
Massachusetts*
Michigan
Mississippi
Missouri*
New Jersey*
New Mexico
New York
North Carolina
North Dakota*
Ohio*
Oklahoma
Oregon
Rhode Island
South Carolina
Tennessee*
Virginia*
Washington

* not limited to coverage of cancer drugs only



CFMC Receives CDC Award for Flu Campaign

The Colorado Foundation for Medical Care (CFMC) has received an award from the Centers for Disease Control (CDC) in Atlanta for its campaign to increase influenza and pneumococcal (flu and pneumonia) vaccination and tuberculosis (TB) screening among Colorado nursing facility residents.

The award, also sponsored by the Health Care Financing Administration (HCFA) and the National Coalition on Adult Immunization, was presented to CFMC Medical Director Thomas Dunn at a recent Adult Immunization Conference in Atlanta.

By providing education materials for residents and their families and training materials (including a video) for facility staff, CFMC increased immunization and screening rates between 1995 and 1997 by the following percentages:

- Influenza vaccination rates rose from 84% to 90%
- Pneumococcal immunization rates increased from 22% to 47%, and
- TB screening rates rose from 61% to 80%.

"These diseases represent especially important health threats for long-term care residents," Dr. Dunn noted. "I'm proud of the gains our organization, in collaboration with Colorado's nursing facilities, was able to achieve in this area."

Definitely Win - Win!

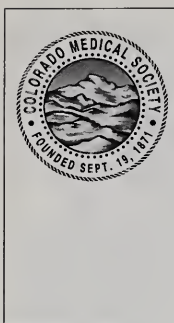


It was a happy occasion for both donor and recipient when the Colorado Medical Society Alliance Co-President Sue Forester presented Dr. Richard Krugman, Dean of the University of Colorado School of Medicine with two checks, totaling over \$ 14,000.00. The checks represent the Alliance members' 1997-1998 CMSERF and AMAERF fund-raising. This money goes into the Dean's discretionary fund to aid medical school students in special projects. The presentation was made at the CMS Board meeting of July 31. Dr. Krugman also presented his report from UCHSC to the CMS board members, reporting first that the move to Fitzsimons Hospital, when in full progress, will still take 5 or more years to complete. There are still serious fiscal questions about how the school will accomplish this move.

1998-1999 "Medical Office Resource Book"

The 1998-1999 issue of the Colorado Medical Society "Medical Office Resource Book", later than usual, will be shipping to members in mid-August.

Though the book is best known for the CMS membership directory, the book contains much usable information for all medical offices.



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Congratulations and welcome to these newly elected CMS members!

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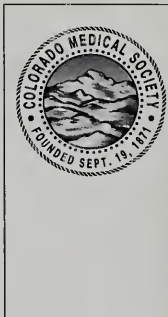
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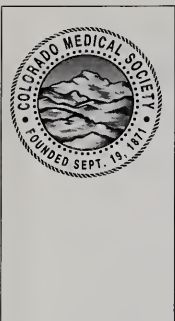
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01/0898

Doctor:

- Does the managed care "bottom line" prevent physicians from remaining true "patient advocates?"
- In questions of business versus patient needs, nothing is simply black or white; how are the "shades of gray" handled by managed care?
- Is it possible for patient advocacy, in the traditional medical sense, to coexist with managed care needs and/or requirements?
- How must "traditional medicine" change to fit or interface with managed care?

These and other questions about managing managed care will be asked and, hopefully, answered at the Colorado Medical Society Annual Meeting.

Be there! Be a part of the solution and get answers for your practice.

AM 98

**Steamboat Springs, Colorado
September 11-13, 1998**



RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by Bill Pierson
Managing Editor

Oh, the incongruity of it all!

I guess for years I have concentrated on "incongruity" in life's little sidebars. I didn't actually realize what I was doing. For instance, when I am walking in the city, I look down at the ground a lot because I find interesting things lying about which have gone generally unnoticed by others. Of course, I find lots of things there that I would not touch or pickup or even talk about here, but that doesn't discourage me from continuing this curious practice. When I read something I am concentrating more on the message conveyed which the writer did **not** mean to convey. Example: A card in the mail the other day touted the "recovery" of children gone missing. The message stated: "Over 85 children from this promotion successfully recovered." Did the writer mean 85.2 children? Or did the writer mean thousands more than 85?

Why must people believe that this sort of excessive verbalizing adds a desired emphasis, when in fact all it does is emphasize the ridiculousness of the statement? So few Americans actually pay any

attention to their language any more. I am amazed that we do any factual, effective communication at all, because there are so many ill-conceived messages.

We have been driven to this "miscommunication" in great part by the "OSHA Syndrome," the fact that through workplace and product liability we feel necessary to over-explain everything, which leads to further ridiculousness and incongruous, pointedly foolish statements. Another example: I watched a man unwrap an office bulletin board which was fancied up with two doors over the board, each door with a clear plastic window. On the plastic window was a blue plastic cover. On the cover was a sticker with the announcement "**Peel off plastic cover before using.**" Let me put forth the obvious question: why would anyone buy a bulletin board covered with two doors containing transparent windows which are covered with an opaque sheeting, without removing the sheeting before trying to display anything on the bulletin board?

This all reminds me of (true story) the miner up in the Wyoming mountains who was ordered to stand an OSHA inspection at his mine. When the inspector got through with looking at the mine, inside and out, he put the mine owner to some questions for the form, such as:

- How many people are employed here? (*No one but me, and I am the owner and only miner.*)
- How many shifts do you run in the mine? (*I work in the mine whenever I feel like it.*)

- What are your qualifications for employment? (*I don't have any since I don't hire anybody.*)

The long and the short of it is that the OSHA inspector cited the mine owner for not having a first-aid kit and a stretcher available at the face of the mine.

Rules is Rules, and the rules say you must have a 2-man stretcher available at all times, even if you run a 1-man shop. You'd better have a stretcher, regardless of how pointedly foolish the requirement seems.

We all run into these kinds of communications but have become so accustomed to misuse of words, faulty syntax, and so on, that we have resorted to mentally decoding each message as it is received, and assuming that we understand what the communicator was **trying** to convey.

Why can't people say what they mean? In my opinion it is because so many of us have become so sloppy in our speech habits that we simply can't effectively or correctly use our language any more. Whatever you say, the Americanized English can still be attractive and highly effective in its proper use. We have stripped it of much of its desirable flavor substituting slang and "street talk" until American English is scarcely recognizable.

Call me a curmudgeon... if that's what you mean to call me. I can be very crusty and ill-tempered when it comes to speech.

I like oxymorons, too. One of my favorites is describing the person as "**legally drunk.**" Now, really!

More on oxymorons another time.

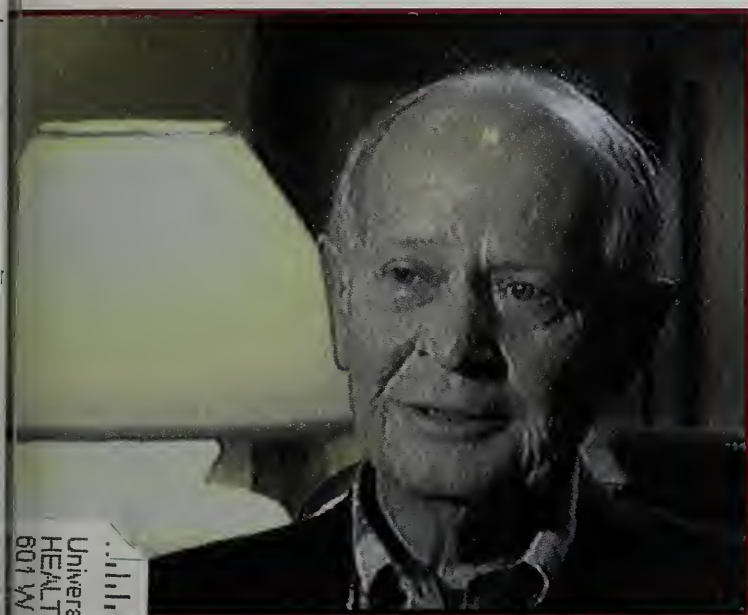


COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

September, 1998

Volume 95, Number 9



From on-air television/Ch. 9 KUSA News

Ray J. Rademacher, MD
winner of the "1998 9 Who Care" award.

and....

- The three "A"s
- Y2K: Mean anything?
- 1999 General Assembly
- Letter
- Physician Pitfalls
- Pain Management
- Off-label drugs

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Claim-Oriented Medicine Pitfalls by John Hughes, MD, Chair, Workers' Comp Cmte	page 302
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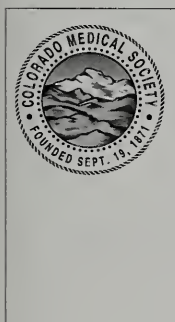


COLORADO MEDICINE



Cover Story

Ray J. Rademacher, MD, named in August as one of the winners of the **9 Who Care** award for their volunteer efforts. *See page 303.*



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PRESIDENT'S LETTER



Gary D. VanderArk, MD
President, 1987-1988
Colorado Medical Society

I can't believe my year as your president has already passed (but people my age always seem to say that). Just when I was getting comfortable in the job, George Shanks announced that he was ready to take over. So, as I leave, I would like to say "Thank You" to everyone and use this space to reflect on what has been accomplished this year.

When I became president of the Colorado Medical Society, I promised you that we would do something about Advocacy, Accountability and Access. With the wonderful support of committees, councils and staff, I think the track record is remarkable.

Of course, your society is about Advocacy. CMS exists to advocate for you the physicians and we have done that with the public, the legislature, managed care organizations as well as the state and national governmental agencies. We have asked you bring your problems to CMS and you have done so in record numbers. I think the Hassle Factor Project stands out as our major accomplishment in advocacy this year.

We have also had an exceptional year as far as Accountability is concerned. In May 1997, we had a leadership conference on this topic and everyone was amazed at the expertise we have right here in Colorado. *Colorado Medicine* has informed you of the kind of leaders in accountability that we have in our state. The Data Committee became the Accountability Committee and led the way to our Joint Data Project involving a cooperative effort with nine HMO's on the management of

diabetes. I think this project will provide a model for other state medical societies and become involved in accountability and will model for us how we can do programs in other diseases.

Although I think we have made great strides with our first two A's, there is no question that my #1 priority has been on Access. In March of 1997 when we had a meeting, which we called Caring for Colorado's Medically Underserved, I had no idea that we were starting a tidal wave. As a result of that meeting, a committee was organized. The committee became a Coalition. The Coalition on the Medically Underserved has grown like a malignancy to involve more than 60 members from all segments of society. We have included consumers, business, the legislature, all state health agencies and departments, hospitals, foundations, insurers, safety-net institutions and physicians to produce an action plan that will provide access for all of Colorado's citizens. Our vision simply is to develop a system for health care financing and delivery that ensures that none of the following are barriers to the receipt of medically necessary care: socioeconomic status, language and culture, age, gender, geography, insurance status, and distribution of facilities and providers.

The Coalition finished the first phase of its activities on September 2, 1998 and distributed its action plan to its constituencies. The plan will be modified on the basis of input from the groups represented and then phase two, the implemen-

"I promised you that we would do something about Advocacy, Accountability and Access."

tation, will begin. The plan is very simple but comprehensive. There are two broad goals: first of all, to immediately expand access, and secondly, to achieve health insurance coverage for all Coloradans through a variety of public and private mechanisms by 2007.

Colorado was the first state to gain approval for non-Medicaid system of health care for children using federal dollars from the CHP+ program. Our plan envisions the gradual expansion of Colorado's Child Basic Health Plan which will be followed by an Adult Basic Health Plan. Insurance coverage for all will be incremental and evolutionary as funds become available.

(Continued on following page)

PRESIDENT'S LETTER *continued*

The immediate improvement in access involves all aspects of health care. We seek to strengthen and enhance funding for the safety-net providers - Denver Health, University Hospital, the Community, Rural and Immigrant Health Centers, local health departments clinics, and the Veterans Administration hospitals -

but we also envision an increase in volunteer effort by all providers. The Coalition also envisions an increase in volunteer effort by all providers. The Coalition will publish in the fall an astonishing catalog of community efforts at meeting the needs of the underserved. We believe that these programs can do even more. If everyone does a little bit, no one will have to do too much.

Can we do this? I believe with all my heart that we not only can but we must. I have come to the end of my term as your president but, we have only come to the beginning of our action plan for access. So, I pledge to you that I will see it through. I will continue to represent you in making this action plan a reality. Colorado can be the first state with health care for all.

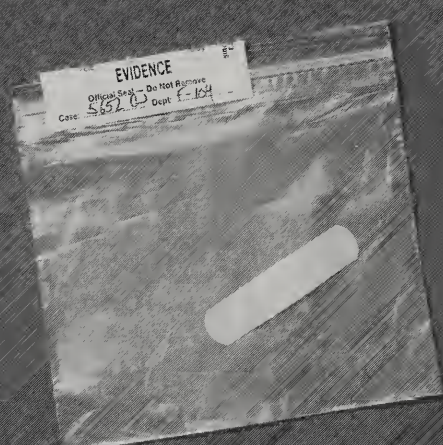


Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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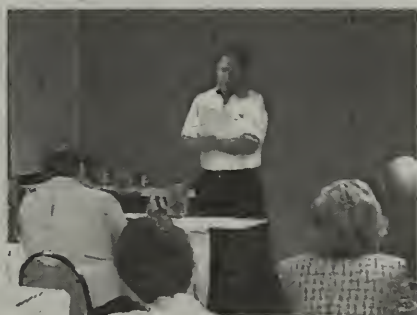
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Colorado Farm Bureau continues support for CMS "CROP"

The Colorado Farm Bureau, a strong supporter of CMS CROP (Colorado Rural Outreach Program) continues to look for ways to help. In July, the Farm Bureau Annual Meeting was held at Vail, Colorado. CMS Foundation Board member Dr. Jack Cletcher, Jr., spoke to the Bureau's county presidents. The principal new message Dr. Cletcher delivered to the group was that CROP has broadened its range of help to rural area health care. It is not limited to the placement of physicians and repayment of education loans for medical graduates. He introduced the idea that there are many more ways now open to other organizations to help.

Dr. Cletcher, himself a rural physician and "gentleman farmer," spoke from the heart when he said CROP is a sorely needed program in many parts of the state.

Buford Rice, (right) CMS Foundation Board member and spokesperson for the CMS CROP program, introduced Dr. Jack Cletcher to Farm Bureau county presidents at the Bureau's Annual Meeting in Vail.



Dr. Jack Cletcher (left) presenting the "CROP" message to Colorado Farm Bureau County Presidents. Dr. Cletcher devotes much of his free time to speaking on behalf of CROP.



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1998



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CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Fall Clinics of Montrose, Colorado

September 25-26, 1998
Montrose Memorial Hospital
Montrose, Colorado
Contact: Kathy Holman
(970) 240-7397

15th Annual Santa Fe Colloquium on Cardiovascular Therapy - sponsored by American College of Cardiology

October 8-10, 1998
Eldorado Hotel
Santa Fe, New Mexico
Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

Medicine in the Rockies

October 17-18, 1998
Cheyenne Mountain Conference Resort
Colorado Springs, Colorado
Contact: Erma Francois
(719) 776-5184 or ErmaFrancois@centura.org

The Association of Managed Healthcare Organizations 1998 Fall Forum

October 11-13, 1998
J.W. Marriott Hotel
Washington, DC
Contact: Elisa Ricciuto
1-800-642-2515 or www.amho.org

Update and Review of Internal Medicine 1998

October 11-16, 1998
Marriott Hotel
Albuquerque, New Mexico
Contact: Dorrie Murray
(505) 272-3942

Communicating Expectations: Patients & Physicians

October 21, 1998
Holiday Inn Denver Southeast
Denver, Colorado
Contact: Mary Fletcher
(303) 695-3399 or mfletch@cfmc.org

Physician Finance University - sponsored by Paramount Physician Network, Century Capital Group & SKB Business Services

October 22 & 29, 1998
Doubletree Inn
Aurora, Colorado
Contact: Tracy
(303) 355-9050

The 30th Annual Cardiovascular Conference at Snowmass

January 18-22, 1999
Snowmass Conference Center
Snowmass, Colorado
Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

Clinical Diabetes & Endocrinology

January 24-28, 1999
Snowmass Conference Center
Aspen/Snowmass, Colorado
Contact: Donna Loy
(303) 789-9682 or 1-800-421-3756

Ski & CME Midwinter Conference, sponsored by Colorado Society of Osteopathic Medicine

February 21-26, 1999
Keystone Lodge & Resort
Keystone, Colorado
Contact: Patricia Ellis
(303) 322-1752 or (800) 527-4578

The 6th Annual Echocardiographic Workshop on 2-D & Doppler Echocardiography at Vail - sponsored by American College of Cardiology

February 22-26, 1999
Vail, Colorado
Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

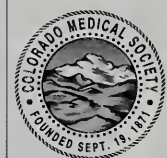
Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society



We could fill several pages talking about this year's legislative session and the many changes that will result in our Colorado House and Senate in 1999. However, I will spare you. I think all the important details have been well represented in our Board meetings as well as through the reports by Dr. Chris Unrein, Legislative Council chair. What I want to say has to do with what you (the individual physician) and Colorado Medical Society (the organization) have to do in order to have any effect on legislation in the coming year.

In years past this organization has done pretty well speaking on behalf of patients and physicians with one voice. The leadership of CMS has emphasized this by stressing the importance of physician-testifiers at state legislative committees ONLY representing CMS and not be identified with an independent opinion. Why? One of our presidents stated some years ago that "trying to lead a group of doctors was like trying to herd cats". The same philosophy applies in legislative hearings: one voice on behalf of all physicians in the organization and not independent, personal opinions which are, nevertheless, usually perceived as CMS views.

Many issues have become volatile simply because a number of physicians testified based on personal emotion more than from sound medical reasoning. Emotion alone won't get it. CMS must go to the legislature with a single position!

If there are issues on which you wish to speak out, fine. So that we don't step on one another's toes,

please go through the proper CMS committee or council.

Why make such a point of this now... during the "dog days" between legislative sessions? Because every day we look at the newspapers and see further instances where physicians are demonstrating more animosity toward one another than they are toward outside influences. We are seeing more and more competition between physicians. There's always been competition, but now there is a zone of unrest - near distrust - in which physicians even of a like specialty are having trouble talking to one another.

Of course, my perspective is from the organized medicine view: we have difficulty maintaining a balanced approach to OUR job. Why, you ask? Because staff is spending a lot of time just keeping CMS out of these physician-to-physician skirmishes. We don't belong (and won't get involved, if I can help it) in these localized pitch battles. But I hope you can see what the fierce competition for patients is doing to the proud profession of medicine. It is opening fissures in the otherwise united advocacy for patient and physician. If you don't want to talk to one another, then where is the common cause which are the rivets of an organization? We've popped some rivets and the slow leakage is showing up.

I liked my July report on how much (how very much) CMS was doing for its members. (Remember the life-preserver?) But I re-emphasize **what you, the members have to do** so that CMS can help.

"We've popped some rivets . . ."

Competition is one thing, but the kind of competition surfacing now among physicians is not good for common goals and purposes. We see more and more how the physician's practice (and very life) is now decided by the insurers, the HMOs and managed care plans. They dictate how the physician will practice medicine. Unless you can all maintain your professional status, this IS the future of medicine. Is this what you want? I'm sure not!

So come home! To CMS. Let's work more closely together and be ready for the 1999 General Assembly session. There's plenty for each one of you to do, and CMS is here to focus your efforts into one major force and unit. We have already seen in the primary election that 1999 is not going to be easy or necessarily "physician-friendly". Let's head it off at the pass and be involved when the general election rolls around. Call us!



Colorado Physician Pitfalls in Claim-Oriented Medicine

by John Hughes, MD, Chairman
Workers' Compensation &
Personal Injury Committee



***"A large amount of
gaming may go on ..."***

All primary care physicians and most specialists are aware of certain patients they see in a claim-oriented setting. They include work-damaged individuals and people injured in motor vehicle accidents. These people may or may not be at fault, but all have come to the physician for medical care. Most doctors groan privately (or publicly) about the special burdens and hassles that seem to accompany such patients. However, many doctors correctly recognize that in an environment of heavily discounted reimbursement the claim-oriented patient is adequately covered by traditional types of insurance.

I am an occupational medicine specialist (amazingly by choice) and my purpose for this article is to provide Colorado physician with some tips that will minimize the hassle factor and optimize reimbursement.

Here is a piece of groundwork: unlike other areas of medical practice, communication with carriers is needed to mobilize additional non-medical insurance benefits for your patient. These include temporary total disability, essential services, or permanent disability awards. Such communication is a necessity and must come from the physician. Hence, this is a reimbursable medical activity. I will walk you through a few of the most common communication scenarios.

Workers' comp comes in several flavors of federal comp as well as comp for all 50 states. Yes (groan) all 50 states have distinct rules that govern workers' comp! Yet some common rules exist. At each visit, state physical restrictions in your report. Do not make a judgement that the individual should be "off work" unless you are justified by a commonly accepted "disability advisor" or you have carefully reviewed an essential function analysis for the job. Insurers and employers have a right to know physical restrictions for your patient at each visit with you. Yes, the extra time it takes to delineate your patient's restrictions may be used to upcode the visit. If you have to do this in a separate case review, make sure you bill at the fee schedule rate or your usual income "pace", whichever you chose. Avoid state-

ments like "light duty" this term is meaningless coming from you. Accommodating your restrictions is the employer's concern, not yours.

Permanent impairment determination usually requires special attention to the particular rules of the jurisdiction covering the claim. Read the request letter carefully and adopt particular guidelines and language when required. In Colorado, the term "impairment" will equate to the Wyoming term "ascertainable loss" just as the Colorado term "maximal medical improvement" refers to the same "point of stabilization" reached in Wyoming. Naturally California has its own arcane system where English modifiers like "very" and "extremely" are added to increase the disability determination. Remember that in Colorado you need to be certified by the Division of Workers' Comp to do impairment ratings. Stick close to objective physical findings, determinations of range of motion and function, and other translatable findings and you will do fine; an in-jurisdiction physician can perform the actual rating from your clinical findings. It would be good for you to get a copy of the out of print ***AMA Guides to the Evaluation of Permanent Impairment, Third Edition (Revised)*** from the Colorado Division of Workers' Compensation (303) 575-8700.

A large amount of gaming may go on by individuals intent on showing how much they have suffered from the accident through no fault of their own. This is a particular feature in property slips and falls and in motor vehicle accidents. When I am in a particu-

larly dark mood, it seems that there is an actual force field protecting the individual who caused the accident compared to the hapless "victim"! There are also high income medical experts in Colorado's larger cities that will comprehensively treat subjective symptoms stemming from the most low-energy accident imaginable. Beware the individual who wants endless massage therapy and modalities as these things may not be therapeutic at all but rather measures taken by the individual to provide a proxy for severity of injury in a legal forum. There are guidelines that can help you out, particularly where you are trying to contain an endless series of treatments. Do not be afraid to get a second opinion on yourself. This is particularly helpful if your patient perceives that you are terminating a benefit the patient wants to continue. Be sure you are objectifying therapeutic gains by measures of return to work or measurable increase in function rather than by strictly relying on subjective feedback from the patient. Attorneys represent many of these patients. Like the insurance companies, the attorney may request particular information about your patient / their client. Again, a case review or letter may be required for this communication. I would encourage you to offer the same services to the attorney you are required to provide to the insurance company.

In summary, taking care of the claim-oriented patient requires a special eye on communication to interested parties. Particular attention is needed in communicating current physical restrictions at the time of each visit. Avoid blanket statements of "off work" without substantial justification or use of a disability guideline. Pay attention to treatment type and duration when using allied professionals like massage therapists. It is possible to offer these patients the same type of thorough care you provide other patients and for this type of care to be a rewarding experience.

Congratulations. . .



From on-air television/Ch. 9 KUSA News

Denver Pediatrician Ray J. Rademacher (left) walks with Glenn Tuthill, a member of the Qualife Men's Group outside the Qualife Wellness Community Center at 1714 Poplar.

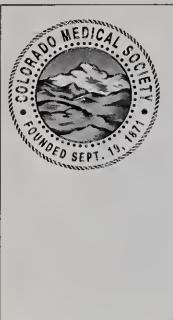
.... to Ray J. Rademacher, MD, named in August as one of the winners of the **9 Who Care** award for their volunteer efforts. Dr. Rademacher, a retired Denver Pediatrician, has worked with the Men's Group at Qualife Wellness Community for the past three years. The group is made up of men who are suffering a terminal illness or are undergoing treatment for an illness but have no family or loved one's support.

Dr. Rademacher has been friend and medical counselor to many. He has been at hand for some in their last days, helping them face the grim task of dying. He said it helped him as well.

This is not the only time Dr. Rademacher has been a standout in the local news media. He, like many other physicians, was so appreciated by his patients during his practice that over 200 of them (former and current patients representing 2 generations) gave him a "thank you" party before his retirement. It was big enough that the Rocky Mountain News devoted nearly a whole page to the story and photo.

Of the **9 Who Care** award, Dr. Rademacher said he appreciated the recognition but the experience, he said, was valuable to him. He said "There were a few patients I've been fortunate enough to be with them... to walk them to the door - and it was important to both the patient and myself - to have a sense of completion to our mission. It was a valuable experience and one I will cherish."

Dr. Rademacher, the Men's Group leader at Qualife, was described by man in the group as having helped the patients face the facts of their situation while giving them strength to deal with life on this plateau.



THE LOBBY



by Christopher Unrein, DO, Chairman
Council on Legislation

"... we must avoid behavior that aids in the loss of control."

The November election is an important one. As a result of term limits, nearly one-third of the legislature will turn over, including all leadership positions. There will be a new governor as well. State leaders will work with our national congressional lawmakers to redistrict our state after the 2000 census, and Colorado will probably gain a seventh House seat in 2000. All of this is in the wake of campaign finance reform and term limits changing how campaigns are structured. The result is that the next election will have far reaching implications; we are choosing these leaders with an untested set of rules.

This is important because the attack on the practice of medicine is real and ongoing. Non-physician health care workers will demand their "slice of the loaf," as it was put to us by the chiropractors. With all of these freshman lawmakers at the state level, Colorado Medical

Society's members need to be directly involved with their local legislators. They need to be educated in order for them to understand our concerns about quality patient care; these are not issues about turf! In the past, legislators have perceived our policies as protectionism, not as patient advocacy.

I have recapped my previous articles to remind you that the attack against the practice of medicine as we know it is real. And now this threat extends beyond our legislators. The next testing ground for the erosion of physician's autonomy and professional status is in the Colorado constitution. There are three initiatives on the November ballot that will directly impact medicine.

First, the CMS Board of Directors unanimously endorsed the recommendation of the Council on Legislation to oppose the legalization of marijuana for medical purposes. The other two constitutional amendments regard the physician-patient relationship more intimately.

They are the prohibition of partial-birth abortions and the mandatory notification of parents for a minor having an abortion of any kind. Not only would these amendments interfere with the physician and the patient having an unencumbered relationship, but the partial-birth abortion initiative uses horrifically graphic but scientifically imprecise terminology. This initiative also would place criminal acts of "medical" practice outside the discretion of the Colorado Board of

Medical Examiners, where the self-discipline of the medical profession belongs. In the July 23 issue of the *New England Journal of Medicine*, an article by George J. Annas, JD, MPH clearly evaluates these issues and concludes, "...when professional organizations determine the content and scope of reasonable medical practice not on the basis of their professional skills and the health interests of their patients, but rather on the basis of their reading of the prevailing political winds, they undermine their own credibility and explicitly agree that standard for medical practice should be set by politicians rather than the medical profession."

The concept that the medical profession should guide the standards of medical care is the philosophy by which many of the Council on Legislation's decisions are made. As divisive an issue as abortion of any type is, this is not the concern of the Council. Preservation of the professional realm of medical practice is our concern. Physicians need to unite and use the legislative process to maintain our autonomy and our professional judgement for the well being of our patients. We also need to understand when to stay away from the legislative and legal process, for the law of unintended consequences will surely raise its ugly head.

I recently read a book called, ***The Death of Common Sense*** by Philip Howard. It highlights the overuse of process and procedures. Howard presents a variety of

(Continued)

THE LOBBY (Continued)

examples of absurd regulatory power, and those examples can easily be extrapolated into the frustration of modern day health care. This book should be mandatory reading for every physician active in practice. It emphasizes that good intentions are usually the driving force for various rules, but that the results can be totally ridiculous. The most important point of the book is that you can not regulate or promulgate for every potentiality. As Howard puts it, "Human activity can't be regulated without judgment by humans."

The practice of medicine is our judgment and experience. These are the qualities that the bureaucratic process is striving to remove from the practice of medicine. They are the very things that we went through medical school and residency to obtain. We must not succumb to non-medical control of our profession any more than we already have. This means we must avoid behavior

that aids in the loss of control. Let us separate medical practice from personal beliefs and desires. Let's get back to the days of physicians and patients working together, without outside influence intruding into the exam room. Let's agree to disagree on divisive issues for betterment of the profession of medicine as a whole.

Get out and vote on November 3rd and remember that our profession is in a vulnerable position. Don't contribute to this vulnerability.

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Reimbursement for Off-Label Use of Drugs

by Edie Register, Director
CMS Division of Health Care Finance

*This article was first published in the August, 1998 issue of **Colorado Medicine**.
We have been asked to reprint the article this month.*

Many health insurers limit access to "off-label" uses of approved drugs

Off-Label Drugs

So-called "off-label" drugs are those approved by the FDA for one condition, but prescribed by a physician for another diagnosis. Use of "off-label" drugs, which have been reported in accepted medical compendia, may be an appropriate treatment regimen for many patients. (The federal government's General Accounting Office estimates that about 56% of cancer patients received an off-label drug.) At this time Colorado law does not require insurance companies to pay for these drugs, although the companies may choose to do so. Physicians who have experienced problems with payment for off-label drugs are asked to contact Edie Register of the Colorado Medical Society at 303-779-5455 or 1-800-654-5653 with information about the problems you are aware of.

The Food and Drug Administration (FDA) allows drugs to be marketed only for their approved indications. After a drug is approved for one purpose, however, physicians legally may prescribe the drug for other purposes or diseases. This is called "off-label" use of drugs or use for "unlabeled indications." The US General Accounting Office estimates that about 56 percent of cancer patients received an "off-label" drug.

Many health insurers limit access to "off-label" uses of approved drugs by refusing to provide financial reimbursement for them. This presents an undue financial and emotional strain on cancer patients and may result in unnecessary suffering and even death if the treatment is denied.

Requiring FDA approval for every new indication may take more than five years each and millions of dollars on behalf of the drug manufacturers. In addition, once the patent for a drug expires, there is little incentive for the drug company to seek FDA approval for a new indication because the company may not be able to recoup the investment in research without exclusive manufacturing and marketing capability.

The American Cancer Society concurs with the FDA position that "off-label" use of approved cancer drugs may be an appropriate treatment regimen for many patients, as determined by medical experts and prescribed in accepted medical compendia and journals. The American Cancer Society supports legislative and regulatory initiatives to require health insurance companies, Medicaid, Medicare, and public employee

benefits plans to provide reimbursement for "off-label" use of approved cancer drugs, provided that such drugs have been recognized for treatment of the specific types of cancer in established medical reference compendia.

According to the Association of Community Cancer Centers (ACCC), as of July 17, 1997, 28 states had laws for private insurers to cover "off-label" use of drugs:

Alabama*
Arkansas
California*
Connecticut
Florida
Georgia
Hawaii
Illinois
Indiana
Louisiana
Maryland*
Massachusetts*
Michigan
Mississippi
Missouri*
New Jersey*
New Mexico
New York
North Carolina
North Dakota*
Ohio*
Oklahoma
Oregon
Rhode Island
South Carolina
Tennessee*
Virginia*
Washington

* not limited to coverage of cancer drugs only

SAVE Today



by Roberta Burrington
Colorado Medical Society Alliance

Physicians don't need to be reminded of the terrible effect of violence on our families, our health care system and our society. That's why you are invited to help the Alliance SAVE Today . . . Stop America's Violence Everywhere. On Wednesday, October 14, 1998, the Colorado Medical Society Alliance will be participating in the nationwide effort to emphasize grassroots solutions to local problems related to violence.

The public will be encouraged to take part in SAVE Today by displaying SAVE Today stickers on their care bumpers and windows; making their neighborhood, town, county and state "SAVE zones"; turning off violent media programming for the day; and helping a nearby shelter for victims of abuse.

With SAVE Today as its centerpiece, the year-round SAVE Program is a national effort of more than 50,000 physicians' spouses to combat violence and provide support to its victims. Launched in June 1995 by the AMA Alliance House of Delegates, the SAVE Program represents the continuation of a six-year commitment that began when the organization joined the AMA's Campaign Against Family Violence. More than 700 state and county Alliances will observe SAVE Today, involving millions of local citizens, community organizations, and physicians throughout the country.

Recently, Colorado Governor Roy Romer lent support to the Alliance when he signed a proclamation declaring Wednesday, October 14, 1998, SAVE Today. Governor Romer also acknowledged the Colorado Medical Society Alliance for its commitment to ending violence and helping its victims. Some of the past and ongoing programs include:

- Billboards drawing attention to violence prevention
 - Contributions to Safehouses throughout the state
 - Distributing *I CAN CHOOSE* Workbooks to children's programs
 - Providing pamphlets with crisis numbers & safety plans for abuse victims
 - Grocery bags printed with violence prevention material
 - Information regarding violence in the workplace
 - Providing *BABY THINK IT OVER* dolls for use with teens
 - Currently information on Media Violence and its effect on society
- Turn Off TV Day October 14, 1998

Get involved in SAVE Today by ordering SAVE stickers for distribution in your offices to let patients know that they have a role in solving local problems related to violence. To receive SAVE stickers for your patients, or for additional information on how you can be involved in SAVE Today, contact the Alliance at 303-779-5455 or 1-800-654-5653.

**STOP AMERICA'S
VIOLENCE EVERYWHERE**

American Medical Association Alliance, Inc.

This year the focus for the CMSA Health Promotion Committee will be to:

- Elevate awareness of the presence violence in our communities
- Educate ways to prevent and intervene in violence
- Assess health needs in community
- Continue existing programs if they work or choose a new one from the Project Bank Catalogue



by John L. Lightburn, MD
Historian, Colorado Medical Society

Musings and wanderings on the lighter side

Author's Note: In a recent conversation with Dr. Marcus Bond, specialist in occupational medicine, it occurred to me that historians have their own special occupational hazard, namely becoming pedantic, pompous, ponderous and, even worse, boring! So I had a session with my primary exorcist, Bill Pierson. His prescription: "Lighten up." The following is the result of that prescription.

Here are some historical snippets gleaned from the pages of the Rocky Mountain Medical Journal. I found these items while searching through the archives in preparation for a future article on World War II. For several years, CMS collaborated with the medical societies in Utah, Montana and Wyoming and the Colorado Hospital Association to publish the *Rocky Mountain Medical Journal*.

I searched through the volumes published during the war years, 1942 - 1945. This was an impressive journal. Each issue usually had as many as 70 or 80 pages with about 30 pages devoted to scientific papers, 5 or 6 pages devoted to organizational matters and 30 to 40 pages occupied by advertisements. I am sure you will agree that the one serious deficiency was the absence of an 'Archives' column. The price of each issue was 25 cents.

The titles of some of the scien-

tific papers provide some idea of the practice of medicine in the 1940s. Here are some examples: "Brucellosis in Goats (recovery of *Brucella Melitensis* from cheese manufactured from unpasteurized goat's milk)" by George W. Stiles, M.D., Ph.D. of Denver; "The Management of Urinary Tract Infections," by Herman L. Kretschmer; M.D., president of the American Medical Association; "Subacute Carbon Monoxide Poisoning with Cerebral Myelinopathy and Multiple Myocardial Necroses," by Karl T. Neuberger, M.D., and Edmund M. Clarke, M.D. both of Denver; "Uses and Abuses of Sulfonamide Therapy," by James J. Waring, Professor of Medicine at the School of Medicine; "Head Pains Associated with the Brain, its Nerves and Coverings and the Cranial Blood Vessels", by William Rutledge Lipscomb, M.D. of Denver. Here are the titles of the articles in one issue, September, 1942: "The Art of Medicine" by R. W. Fouts; "Salpingitis" by Gerrit Heusinkveld, M.D. of Denver; "Neurocirculatory Asthenia, N.C.A." by Lorenz Frank, M.D. and "Repair of the Peno-Scrotal Hypospadias" by Henry Buchtel M.D. of Denver.

In his paper, "The Art of Medicine", which he read before the annual meeting of the Wyoming Medical Society, Dr. Fouts wrote about the patient/physician relationship and concluded with these prophetic lines: "The future of medicine rests with the individual member of the medical profession. If each will diligently strive to develop and practice more of the 'art,' better

patient-physician relationships can be maintained and private practice will endure." What is happening to our art?

An editorial in 1945 discussed the survey of physicians income reported by *Medical Economics*. The magazine had reported the average gross income of physicians in the United States in 1939 was \$7,365 with a net income of \$4,470. By 1943, the gross income had increased to \$13,606 with a net income of \$8,658. In four years, the physicians' income had nearly doubled. The editorial suggested that the increase had been the result of physicians working longer hours with so many of their colleagues away in the military service. Busy as the doctors were, they had time to write fairly long articles, sometimes ten pages long, and then read them at a meeting of their colleagues. The article gives a good picture of the level of scientific medicine before the post war explosion of medical technology and science.

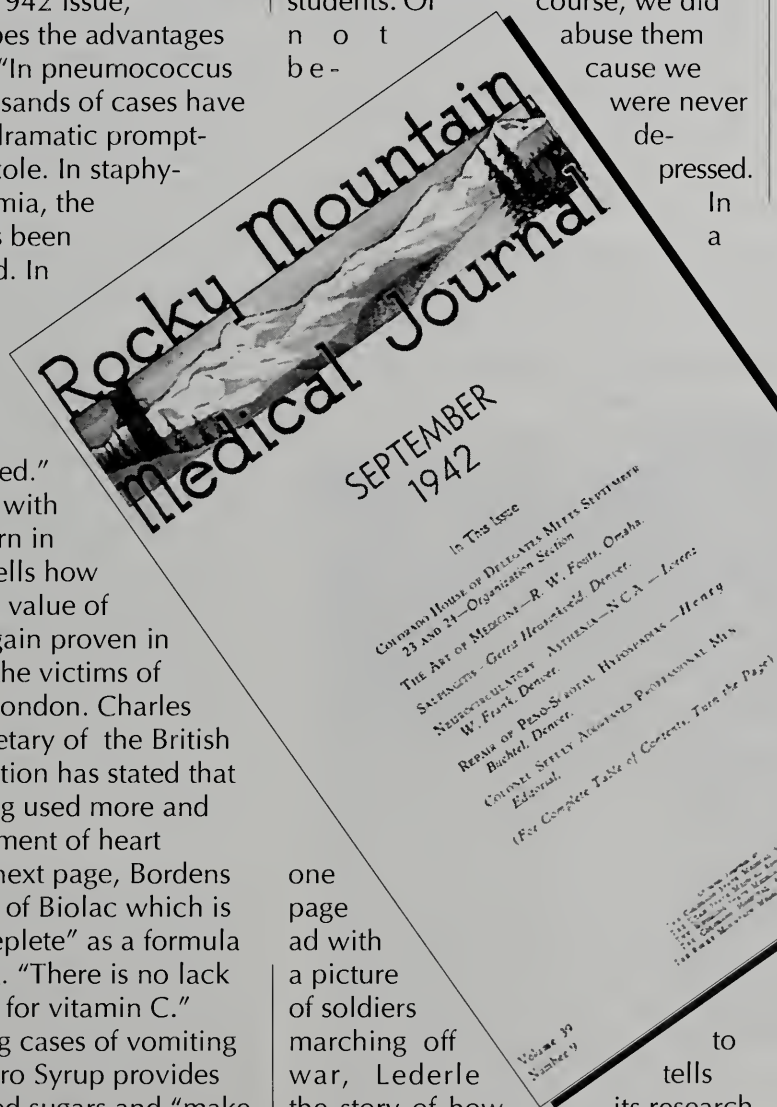
But before this article gets too heavy and ponderous, let's turn to the advertising pages where sanitariums and psychiatric hospitals encouraged doctors to refer patients to them. Pharmaceutical houses had colorful and impressive ads. In a full page ad, Upjohn encouraged physicians to prescribe "Racephedine Hydrochloride in isotonic modified Ringers solution for use as nose drops in the treatment of the "common cold" in children and adults. In another full page ad, Parke-Davis described the advantages of using Theelin and Theelol in "the treatment of the

stormy symptoms of the menopause" and other estrogen deficient states. In large bold print, Merck and Co. tells the physician "In cases of arterial hypertension, when a cure cannot be effected or controlled by rest and dietary means, employment of medical treatment is suggested. Among the various preparations available, Erythroltetranitrate offers the advantage of reductions in blood pressure sufficiently prolonged so that the administration three times daily may maintain the reduction."

In the May, 1942 issue, Winthrop describes the advantages of Sulfathiazole. "In pneumococcus pneumonia, thousands of cases have responded with dramatic promptness to Sulfathiazole. In staphylococcus septicemia, the mortality rate has been strikingly reduced. In gonococcus infections, early cessation of discharge and complete cures have been reported." In a half page ad with the headline "Born in the Blitz", Ciba tells how "the resuscitative value of Coramine was again proven in the treatment of the victims of the bombing of London. Charles Hill, deputy secretary of the British Medical Association has stated that Coramine is being used more and more in the treatment of heart failure". On the next page, Bordens extols the virtues of Biolac which is "complete and replete" as a formula for infant feeding. "There is no lack in Biolac, except for vitamin C."

For managing cases of vomiting in pregnancy, Karo Syrup provides readily assimilated sugars and "make it an ideal carbohydrate to combat the dangerous ketosis of pregnancy. Physicians may write in for a free "Infant Feeding Manual". On page 149, Smith, Kline and French describe the benefits of Benzedrine Sulfate in post encephalitic Parkinson's disease. "It will often produce marked symptomatic improvement, especially when administered with hyoscine, stramo-

nium or atropine. With this combination, drowsiness, muscular rigidity, tremor and lowered mood are relieved. Normal dosage: 20 to 40 mg. daily." That dose should keep all of us awake! In a subsequent issue, Benzedrine is recommended as an ideal medicine for depression. The physician is cautioned to maintain a continuing supervision of the patient to avoid possible abuse. I remember Smith, Kline, French detail men passing out Benzedrine to the medical students. Of course, we did not abuse them because we were never depressed. In a



one page ad with a picture of soldiers marching off war, Lederle tells the story of how its research made it possible to blood type all servicemen with its new concentrated, dried blood serum which was faster and more accurate. In almost every issue, Koromex diaphragms with its "introducer" were pictured and the physician was invited to write in for a manual on fitting the patient with the correct size. In describing the advantages of Petrogalar, the ad writer wrote, "Even the

rigid schedule of army life makes provision for regular periods of relaxation. Not so in civilian life. In the increased tempo of our civilian life, there usually is no one but the doctor to call a halt to his patient's hectic routine. When the treatment for constipation is needed, remember Petrogalar".

Cutter Laboratories usually had a full page ad describing its array of vaccines; the super-concentrated pertussis vaccine or its trivalent vaccine. E. R. Squibb and Sons offered their brand of estrogenic substance called Amniotin. They describe how it is derived from the serum of pregnant mares. It is supplied as an injectable in oil, in a pessary for intravaginal use and in capsules for oral administration. Meade Johnson present their Brewer's Yeast tablets as the source of vitamin B complex including Vitamin B1, Vitamin G and nicotinic acid. In another full page ad,

Lederle tells of the advantages of Sulfadiazine. A bar graph illustrates the decrease in the death rates of pneumonia from 93 to 53.8 per 100,000 population in the four years that it has been available.

Merck and Company describes its two decades of service in treating neurosyphilis with its Tryparsamide. The ad has a picture of a cross section of the spinal column demonstrating the proper placement of a spinal needle in a spinal tap.

The ads give us a glimpse of the therapeutic armamentarium available to physicians 55 years ago. For drug manufacturers, it was important to sell to doctors. But there are some surprises in the advertising section. In the journal that describes alcoholism as a medical problem, I. W. Harper prints a full page ad describing the pleasures of their gold medal whisky, bottles in bond. And Adolph Coors tells of its scientific efforts to maintain a sterile environment in

their brewery. Most surprising, however, are the ads about cigarettes. Each month Philip Morris had a full page ad promoting its cigarette as less irritating to the respiratory tract. "What better proof of the superiority of Philip Morris? Even more conclusive than the obvious improvement in patients on changing to Philip Morris is this: ON CHANGING BACK TO OTHER CIGARETTES. CONGESTION RETURNED IN 80% OF THE CASES. This was from Laryngoscope, Feb. 1935. Not to be outdone, Camels came back with a two page display ad on pages 236-237. In large banner headlines, it proclaimed, "THE REAL IMPORTANCE OF LESS NICOTINE IN CIGARETTE SMOKE." There were pictures of white coated scientists working in their laboratories. In somewhat smaller print, the ad went on as follows: "When you are advising your patients on the brand of cigarettes to smoke, major scientific opinion agrees on 3 facts: 1. Nicotine is the chief component of pharmacologic and physiologic significance in cigarette smoke. 2. Nicotine is important to the smoker only in the smoke. 3. Available medical research* indicates and Camel's scientific tests on hun-

dreds of samples show (see pictures) that a slow burning cigarette produces less nicotine in the smoke.

"Then here is the important question: Is a reduction of nicotine in the smoke of real physiologic importance to a regular Camel

smoker?" Then the ad comes in with its coup de grace: "A prominent physician states in an important article** on smoking, that when injections of nicotine were increased by only 25%, profound changes in blood pressure occurred." Then the ad invited you to send in for a reprint of this important article. The asterisks referred to an article in a 1929 issue of *Journal of the American Medical Association* and a 1941 issue of *The Military Surgeon*. It makes you want to throw away your Philip Morris and rush down to the corner pharmacy and buy a pack of Camels.

Although Philip Morris continues to promote its cigarette as the

remember free cigarettes being distributed at medical meetings and the ads in the media that told us that more doctors smoke Camels than any other cigarette. Indeed, many of us did smoke. The ads were persuasive; the nicotine addicting. Isn't it great that most have been able to "kick the habit"? How much did the pharmaceutical advertisements influence the doctors in 1940? How much are we influenced today?

Follow up relative to the article on Padua:

Marcus Bond, M.D. called me a few days ago about my article on Padua that Bernardino Ramazzini, 1633-1717, had been on the faculty of the medical school at Padua. Who is Ramazzini? He is the father of occupational medicine. His treatise, *De Morbis Artificum*, was the first systematic exposition of occupational disease, describing the diseases of painters who were exposed to mercury and lead, and the lung diseases of miners (silicosis). He decried the indiscriminate use of cinchona bark (quinine) which he said was only effective in malaria. Dr. Bond, one of the pioneers in occupational medicine in Colorado, told me that occupational physicians have founded a Ramazzini Society which honors their "father". The contributions of Padua to our profession are too numerous to cover in one brief paper.

NOTE:

If there is some specific period, person or phase in the history of the Colorado Medical Society about which you'd like to know more, feel free to suggest to the "Historian" the dates, names of individuals or specific incidents you would like to have researched.

Address your request, by mail, to:
John L. Lightburn, MD, Historian
Colorado Medical Society
P. O. Box 17550
Denver, CO 80217-0550

476 ROCKY MOUNTAIN MEDICAL JOURNAL June 1945

Camel invites you

TO ENJOY THE INTERESTING FEATURES OF THE CAMEL CIGARETTE EXHIBIT AT THE

A.M.A. CONVENTION — JUNE 8 TO 12



- See for the first time the dramatic visualization of nicotine absorption from cigarette smoke in the human respiratory tract—
- See the giant photo-murals of Camel laboratory research experiments in the burning rate and nicotine production in the smoke of the 5 largest-selling brands of cigarettes—
- Keep up to the minute on international news with the Camel Cigarette Traveler's "Flash" bulletins, while you enjoy a supply of slow-burning Camel Cigarettes—
- The smoke of slow burning CAMELS contained less nicotine than that of the 4 other largest-selling brands tested—less than any of them—according to independent scientific tests of the smoke itself!

In the same tests, CAMEL burned slower than any of the 4 other largest-selling brands tested.

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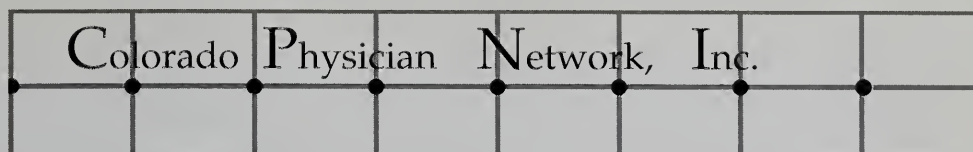
Camel

THE CIGARETTE OF COSTLIER TOBACCOS

best for your health, Camel cigarettes eventually gave up the effort to be scientific. By 1945, they were inciting you to take a break from your busy practice and relax with a Camel, the cigarette with the pleasure factor. My older readers will



David M. Martz, MD
President, CPN



"Tis an ill wind that bodes no good" So the sages have proclaimed for many a year. As we face the changing climate in Colorado health care delivery, we recognize the presence of clouds building in the summer skies.

El Nino has swept across our nation from California to the Atlantic with devastating impact. Analogously, we view with great concern the report that California Advantage, the physician directed health care product of the California Medical Association, has announced its plan to file for bankruptcy protection. Despite a vision similar to our own and subscriber enrollment (7000) approximating Rocky Mountain Physicians Choice (RMPC), they have conceded inability to move forward due to under-capitalization.

Though far from declaring bankruptcy, RMPC is likewise faced with complex challenges at this writing. RMHMO losses, particularly in the Medicaid arena, are not yet fully reversed. Attracting primarily the uninsured "suddenly sick" population, the usual HMO economics of cross-sectional enrollment are not being applied at present. RMHMO is attempting to modify this by redefining the risk and support relationships at the Medicaid state leadership level. In addition, several communities with major Medicaid losses have already been terminated, and more may need to follow before this is turned around.

Marketing efforts are moving forward as outlined previously, with initial focus on the Greeley area, and we are hopeful at this writing of

moving forward there quickly in the next few weeks. In Pueblo, the enrollment of the Pueblo Chieftain employees was recently announced, which provides much needed visibility and credibility in that community.

The revolutionary "3 tiered" product has been approved for the self-insured market, which opens doors not previously possible to large employers throughout the state, and is being met with strong interest. Formal marketing began in July.

We continue to hope and believe that California's experience will not be repeated in Colorado, but we recognize that stormy times may still lie ahead as we enter the continued turbulence of health care's La Nina. All of us who are currently seeing RMPC recipients must renew our individual efforts to provide premium care at economical cost lest summer showers progress to cloudbursts. It is up to us to create the good in the current ill winds. May there be sunshine ahead.

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Health Assistance

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CPHP serves the needs of the Colorado medical community through problem identification, treatment referral, monitoring, clinical consultation and support to individuals and their families.

Physicians who may be experiencing physical, emotional, or psychological problems may elect to refer themselves for evaluation. Family members, colleagues, or other concerned individuals may also provide a referral for a physician in need of assistance.

The Colorado Physician Health program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and providing confidential assistance to physicians with medical, psychiatric or emotional problems in the interest of their own and their patients well being.



ACCOUNTABILITY

Prevention of Colorectal Cancer in Colorado: A Clinical Opportunity

by The Colorado Clinical Guidelines Collaborative

"... advancing the clinical practice of colorectal cancer screening..."

Each year in Colorado there are about 1500 people diagnosed with colorectal cancer and there are about 550 deaths (1). Colorectal cancer is second only to lung cancer as a cause of death from cancer in Colorado. We now have several ways to prevent colorectal cancer: through diet (2), physical activity (3), and chemoprevention (4). Screening is a particularly effective, yet under-utilized tool for preventing colorectal cancer (5,6).

Early detection of colorectal cancer leads both to improved survival, and also to primary prevention. The American Cancer Society screening guidelines call for everyone over 50 to be regularly screened for colorectal polyps and cancer (7), yet fewer than 20% of Americans over age 50 are being screened (8). Screening rates in Colorado are similarly low (9). In a recent study of Colorado residents and primary care physicians, a key factor associated with the low colorectal cancer screening rates was the lack of physician recommendation for screening (10).

Because the most common finding during screening is the

identification and removal of polyps (the pre-malignant lesions that lead to colorectal cancer) screening actually prevents colorectal cancer from developing. Over 90% of those who are diagnosed in the early stages of colorectal cancer survive for at least five years, but survival is much lower for those with more advanced disease (11). Therefore, the potential outcomes of colorectal cancer screening (unlike that for breast or prostate screening) are reductions in both cancer mortality and cancer incidence.

Recognizing the need for consensus on screening guidelines, the Colorado Clinical Guidelines Collaborative has been working in recent months on colorectal cancer screening guidelines. A consensus guideline document was approved on July 14, 1998 (11). We believe that these guidelines will be helpful in advancing the clinical practice of colorectal cancer screening in Colorado in the coming years.

For many reasons, this is an opportune time for Colorado physicians and other health care providers to consider substantially increasing efforts in colorectal cancer prevention: there is scientific evidence of efficacy, screening is now a benefit provided by Medicare as well as many other insurers, and the application of screening guidelines are becoming more widely-accepted.

There is now a high potential for saving lives and preventing suffering from colorectal cancer in Colorado, where the majority of new cases and deaths each year could be prevented through the widespread use of clinical screening methods.

For more information about the Colorado Clinical Guidelines Collaborative and to access guidelines and patient education materials, please visit the Colorado Medical Society's web page at www.cms.org and the COPIC web page at www.copic.com.

The Collaborative wishes to thank Dr. Tim Byers, University of Colorado Health Sciences Center, for his contribution to this article.

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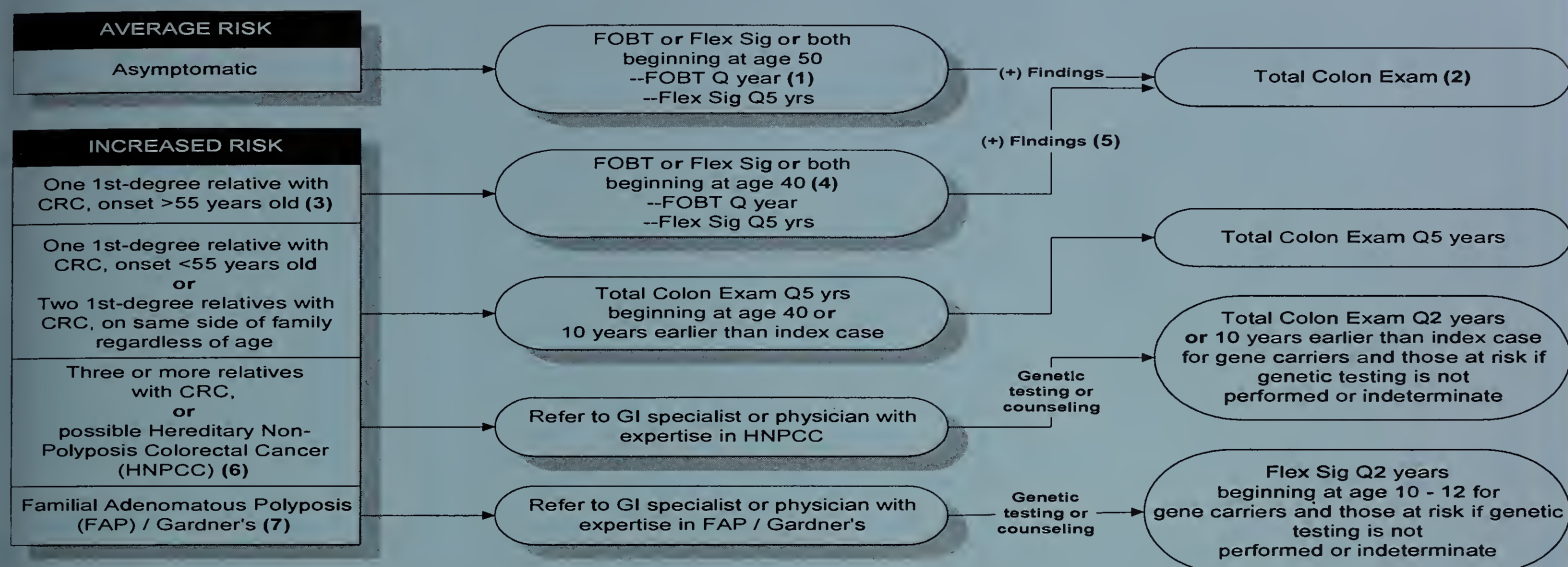
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COLORECTAL CANCER SCREENING RECOMMENDATIONS

RISK

RECOMMENDATION

FOLLOW-UP



- For the asymptomatic patient, FOBT should be performed on three consecutive stool specimens. Prior to the testing, aspirin and NSAIDs should be avoided for seven days. During the three day testing period, vitamin C, red or rare meat, fresh melons, turnips, radishes, and horseradish should be avoided.
- Total Colon Exam includes: Colonoscopy or Double Contrast Barium Enema (DCBE) plus Flexible Sigmoidoscopy. The choice of procedure should depend upon the medical status of the patient and relative quality of the medical examinations. Flexible Sigmoidoscopy should be performed as an adjunct to DCBE. If Colonoscopy does not adequately evaluate the entire colon, DCBE should be performed. Colonoscopy has the advantage to identify, remove, and biopsy suspected tumors and lesions at the time of the exam.
- A first-degree relative is defined as a parent, brother, sister, or child.
- The American Cancer Society recommends flexible sigmoidoscopy and FOBT for screening of this group. However, either or both tests are recommended by the US Preventive Task Force based on the scientific evidence available.
- A positive finding represents adenomatous or villous polyps or adenocarcinoma. Hyperplastic polyps do not require further follow-up unless other risk factors are present.
- HNPCC, also known as Lynch Syndrome I, is an autosomal dominant inherited trait that can lead to adenomatous colon polyps and colorectal cancer. The Amsterdam criteria define this genetic syndrome as: Three or more relatives with CRC, or colorectal cancer involving at least two generations, or one or more cases of colorectal cancer diagnosed before age 50 with one being a first-degree relative of the other two. A referral should be made to a physician with expertise in HNPCC for genetic testing and counseling.
- Familial Adenomatous Polyposis (FAP) / Gardner's Syndrome is an autosomal dominant inherited trait that can lead to adenomatous polyps and colorectal cancer. A referral to a physician with expertise in FAP for genetic testing and counseling should be considered.

Note: These clinical guidelines are designed to assist clinicians in the management of screening patients for colorectal cancer. The guidelines are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition.

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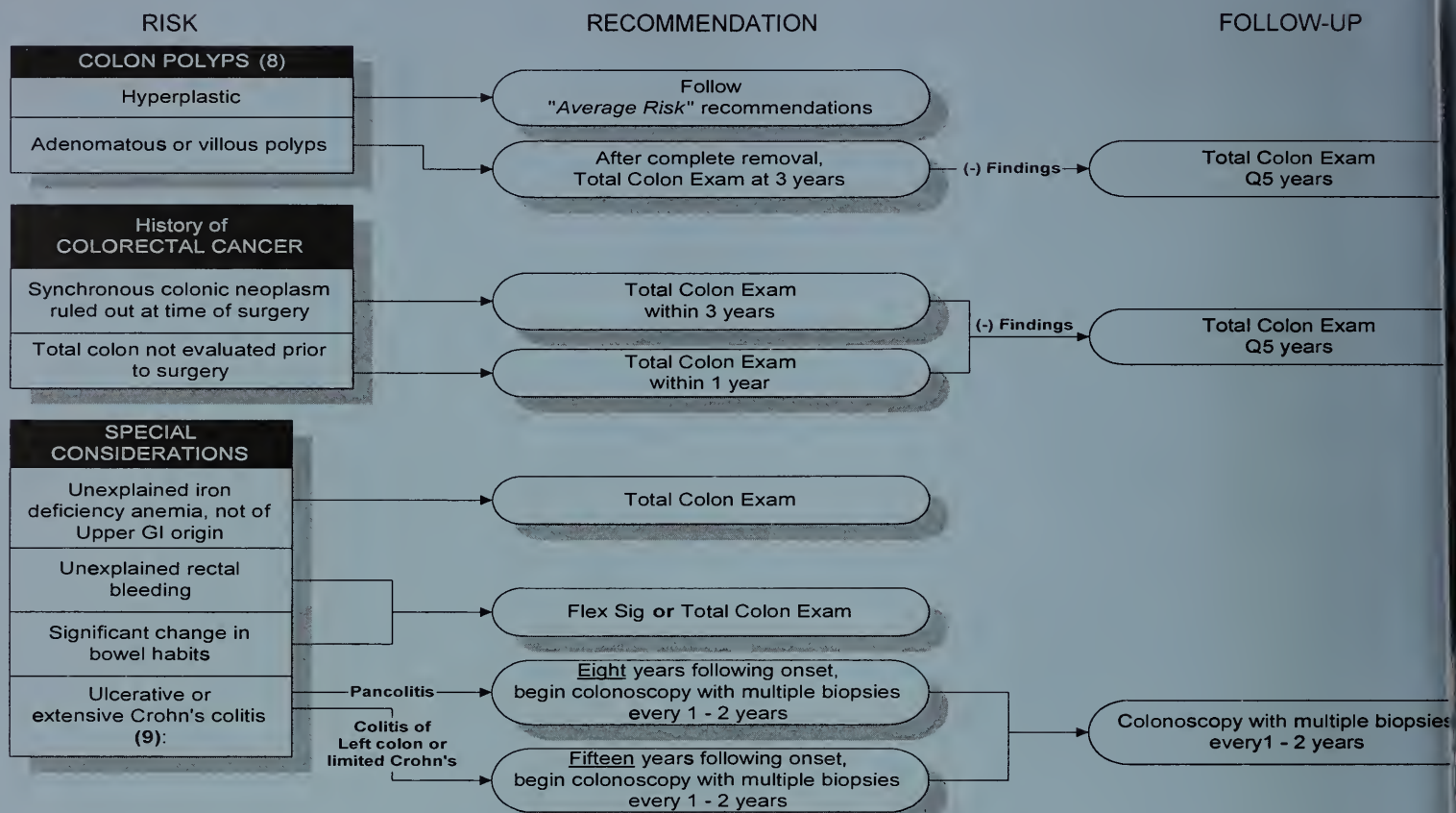
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COLORECTAL CANCER SCREENING RECOMMENDATIONS



8. Individualize screening for each patient: for adenomatous polyps <1 cm, or for age >75, or if life expectancy <10 years based on comorbidity figures.
9. Risk of colorectal cancer increases with extent of disease.

Note: These clinical guidelines are designed to assist clinicians in the management of screening patients for colorectal cancer. The guidelines are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition.

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Dear Reader:

Please take a few minutes to complete this survey so that we may serve you better.

- Prior to reviewing the Colorectal Cancer Screening Guideline in this issue of Colorado Medicine, were you aware of the new recommendations for colonoscopy for high risk patients?
 - ☐ Yes
 - ☐ No
 - ☐ Unsure
- Do you want to receive more clinical guidelines?
 - ☐ Yes, definitely
 - ☐ No, probably not
 - ☐ Yes, probably
 - ☐ No, definitely not
 - ☐ Unsure
- What is/are your preference(s) for receiving new recommendations in the form of clinical guidelines? (Check all that apply.)
 - ☐ meetings, journal article (please specify)
 - ☐ e-mail health plan newsletter
 - ☐ Internet Web Site direct mail
 - ☐ other (please specify)
- What written format(s) for clinical guidelines is/are most useful for you? (Check all that apply.)
 - ☐ journal article
 - ☐ 3-ring binder
 - ☐ one-page summary algorithm
 - ☐ pocket handbook
 - ☐ other (please specify)
 - ☐ electronic
- Specialty:
 - ☐ Family Practice
 - ☐ Internal Medicine
 - ☐ Other (specify)
- Year of graduation from medical school _____
- County in which you practice _____

THANK YOU FOR COMPLETING THIS SURVEY
Clinical Guidelines Collaborative

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by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Patients Free from Pain, Physicians Free from Fear: Copic-Led Effort Aims to Teach Appropriate Pain Management

Imagine that a patient comes to you complaining of constant low-back pain. She's tried everything -- losing weight, exercising, NSAIDs, and surgery. She's unable to work and fears she'll soon be unable to provide even the most basic care for her family. She asks you to prescribe an opioid analgesic. You both know that it would likely have to be used long term. What do you do?

If you're like most physicians, you're hesitant. You're worried that if you do prescribe the requested drug, you'll be exposed to more risk than you may be comfortable accepting:

- The risk of scrutiny from the DEA
- The risk of disciplinary action from the BME
- The risk of a lawsuit if the patient injures herself or someone else while taking the drug
- The risk of creating a "drug addict"

On the other hand, if you tell her "nothing more can be done," you may expose yourself to peer or regulatory criticism -- and maybe even to a malpractice action for failing to provide adequate pain management.

The legal jeopardy that providers face is of particular concern in light of the reportedly high percentage of patients receiving inadequate pain management. In an article produced by a panel of experts and consumers convened by the Agency for Health Care Policy and Research (AHCPR), Robyn S. Shapiro, J.D., with the Center for the Study of Bioethics at Medical College of Wisconsin, notes:

"To avoid liability exposure for failure to provide adequate pain management, it is advisable for health care institutions to educate their caregivers about proper pain control and to develop pain management policies that should incorporate applicable guidelines about pain assessment and monitoring, pain-medication dose calculation and escalation, contraindications to pain medication, and management of side effects." Shapiro, Robyn S., J.D., "Liability Issues in the Management of Pain," *Journal of Pain and Symptom Management*, vol. 9, no. 1 (January, 1994), pp. 129-135.

In its "Guidelines for Prescribing Controlled Substances for Intractable Pain" (adopted May 16, 1996), Colorado's Board of Medical Examiners also urged appropriate pain management:

"The Colorado Board of Medical Examiners (CBME) strongly urges physicians to view effective pain management as a high priority in all patients.... Pain should be assessed and treated promptly, effectively, and for as long as pain persists. The medical management of pain should be based on up-to-date about pain, pain assessment, and pain treatment.... Concerns about regulatory scrutiny should not make physicians who follow appropriate guidelines reluctant to prescribe or administer substances for patients with a legitimate need for them."

I'm pleased to inform you that thanks in large part to the efforts of Dr. George Thomasson and others in our Risk Management department, Copic Insurance Company is playing a pivotal role in the development and pre-

sentation of a curriculum designed to achieve precisely these objectives. Drawing broadly from the state's healthcare community, Copic Insurance Company and like-minded organizations have formed the Colorado Pain Management Consortium.

The Consortium has developed a 90-minute seminar entitled "The Tragedy of Needless Pain: Treating Pain Appropriately." The seminar is designed to educate healthcare providers about the critical aspects of pain management. Presented by a physician and a nurse with current clinical experience in pain management, the seminar debunks the myths surrounding this sometimes overlooked area of medical care and imparts crucial information about recent advances in pharmacology that allow optimal relief. Copic-insured physicians in any specialty earn 1 ERS point for attending the seminar. A list of current seminar offerings can be found in Copiscope or on Copic's web site at <http://www.copic.com/seminars/pain.htm>.

The Consortium plans to offer the seminar at locations throughout the state, and is eager to hear from physicians and other healthcare providers who are interested in championing this cause in their local communities. For further information, contact Richert E. Quinn, M.D., Copic's Assistant Vice President of Risk Management, at (303) 930-0475 or (800) 421-1834, ext. 2475. You may also e-mail Dr. Quinn at rquinn@copic.com, in Copiscope or on Copic's web site at <http://www.copic.com/seminars/pain.htm>.

LETTERS TO THE EDITOR



Editor:

In your August 1998 issue, President Gary VanderArk, MD chastised physicians for "grousing in the doctor's lounge about how bad things have gotten in medicine . . . We've never had it so good. Physician incomes are rising, not falling. Hours worked are going down, not up."

I do not know in which part of the state Dr. VanderArk practices, but it is not in Denver or Boulder. No doctors who I know work fewer hours for higher income, but more hours just to keep the same income, or less. A recent report in *Denver Business Journal* (August 7-13, 1998, p3A) states that specialty physicians in Denver who have contracted with Pacificare are receiving 28% of billed charges in 1998 for reimbursement. This fell from 47% of billed charges in 1997. Yet Pacificare reports record profits, and they have not had to close their skybox at Coors Field (nor have they invited physicians to any games). With overhead charges close to 50% of charges, a physician seeing Pacificare patients loses money.

Physicians have a right to be bitter. When our malpractice company has to offer support groups for physicians who are being sued, insurance for legal fees for Medicare and Medicaid fraud probes and state medical board complaints, our "role to play in life" is ambiguous. Never before have physicians been subjected to vicious onslaughts from insurance companies, regulator, governmental agencies, and yes, even patients.

Physician leadership from the Colorado Medical Society should address these issues. It is for good reason that physicians are not advising qualified students to pursue medicine as a career. Dr. VanderArk should not be "disgusted". Instead, he should exercise his leadership and talk with physician members who practice medicine very well, yet feel very unfulfilled. Seek opinions from members who are too busy to

attend annual meetings and who instead stay in their offices and hospitals and hour or two longer each day than they used to. Then he may "find the right answer to (our) problems and . . . fulfill the tasks which" his position should set for him. We will all be better off for that.

Stephen M. Fries, MD
Boulder, Colorado



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So Who's Got Money To Burn These Days.

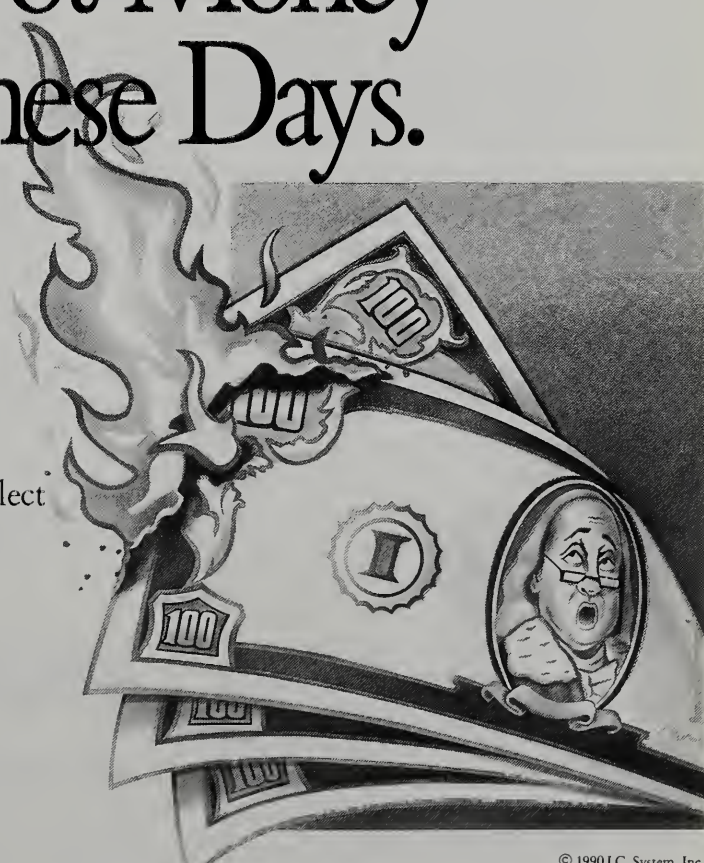
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Highlights of the Colorado Medical Society Board of Directors Meeting July 31, 1998

- I. Ms. Sue Foerster presented Dean Richard Krugman, MD with the CMSA Education and Research Foundation (ERF) yearly monetary gift (this year nearly \$14,000.00). Dean Krugman thanked the Alliance and CMS for their generosity. He spoke briefly about the medical school's plans to move to Fitzsimons. He also stated that all of their second year medical students passed part one of their boards with scores five points above the national mean.
- II. Copic: Dr. Jerome M. Buckley reported that the Physician Insurers Association of America (PIAA) recently published an informational malpractice claims study on neurologic impairment in newborns. Copic is in the process of updating their malpractice insurance rates. Copic has ongoing programs to alert physicians about fraud and abuse, and have added a fraud and abuse "defense only" fund of \$25,000 to their policies. Dr. Buckley thanked Marilyn Rissmiller for her excellent articles published in *Colorado Medicine* on fraud and abuse. Copic has also included a "defense only" fund for physicians who do peer review. This fund covers the physician if they run into legal problems because of their activities.
- III. CMSA: Ms. Sue Foerster reported that she and Leslie Nathan, Co-Presidents of the CMS Alliance, traveled to the different counties to install new officers. Ms. Foerster attended the national meeting of the AMA Alliance in Chicago during June. The Alliance is currently working on publication of their annual directory. Ms. Foerster briefly discussed the agenda for the CMSA meeting during the CMS Annual Meeting in September, and distributed a handout of the Alliance agenda.
- IV. AMA Delegation: Senior Delegate Dr. Richert E. Quinn reported that Dr. Mark Levine did an exemplary job as chair of the task force investigating the "Sunbeam" issue. He stated that our newer delegates are making a name for themselves at the AMA House. Dr. Quinn stated he was successful in his reelection to the Council on Constitution & Bylaws, and thanked the board for their support. The Colorado AMA delegation submitted two resolutions to the annual meeting, which were referred to the Board of Trustees. He reported that Dr. Joel Karlin is planning to run for a seat on the AMA Board of Trustees in June 1999.
- V. Colorado Physician Network (CPN): Dr. Jack Berry presented the report, although he has resigned from their board in order to work for Rocky Mountain HMO. CPN is now in the position to provide care for the Rocky Mountain Physician's Choice patients in any county in the state. CPN is looking forward to a bright future.
- VI. Colorado Rural Outreach Program (CROP): Dr. Berry reported that CROP and the CMS Foundation Board have now collected, in gifts and pledges, about \$220,000, and have spent approximately \$140,000. Procedures for obtaining gifts and grants will be finalized at the next CMS Foundation Board meeting.

The next CMS Board meeting will be held on September 10, 1998 at the Sheraton Steamboat Resort and Conference Center in Steamboat Springs.

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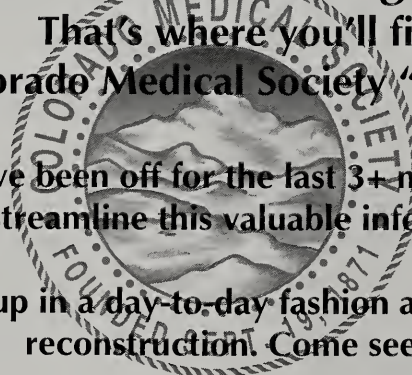
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reconstruction. Come see us!





Are you prepared for the millennium?

Reprinted from August, '98 issue of Reports, a publication of Indiana State Medical Association

As the 21st century quickly approaches, businesses prepare for millennium bugs or glitches causing computer problems when the calendar turns 2000. Physicians also must realize these glitches could cause their offices to run inefficiently or even shut down.

In non-compliant computers, dates are stored in six-digit fields, accounting for day, month and year. The century is implied. When 21st century data are introduced, these computers lose the ability to distinguish between dates.

"Most major health care organizations are doing something about this. However, some smaller groups think it won't affect them," said George Morrell with Data Solutions Inc. a company that provides computer support to physicians. "Most doctors are busy with patients so they haven't had time to think about this," confirmed Donald J. Kerner, MD, vice president, medical affairs at St. Francis Hospital.

If physicians do nothing, they may not be able to schedule patients into the year 2000 or budget past that year. Computers may kick-out insurance policies that expire after 2000 and patients' birth dates could become inaccurate.

Also, the Health Care Financing Administration issued this warning to

its contractors: "... If there's an interruption in medical claims processing because your system is not year 2000 compliant, we are going to consider that a performance error."

To begin to remedy the problem, Morrell recommends physicians take an inventory of equipment to determine what could be affected. Only current software and hardware probably are compliant. If hardware is several years old and not compliant, it may be more effective to buy new hardware. Most Pentium-based or higher computers are compliant.

Even software purchased in the last few years may cause problems. The data may be all right, but when you start inputting information with dates, there may be trouble, said Morrell.

Physicians with big practices or many computers may consider hiring a computer consultant to run tests on systems. But don't wait until the final hour:

- Transition slowly if you're getting a new computer system.
- Test the product to ensure it works properly.
- Understand vendors and consultants will be swamped at the last minute.

Do you want more information? Go to <http://www.rx2000.org>, or the AMA website at www.ama-assn.org.

1999 Medicare budget may include "User Fees"

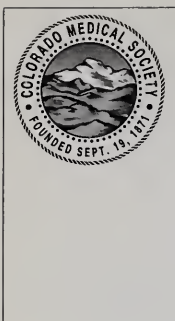
The Administration's proposed budget for 1999 calls for a variety of new user fees (provider taxes) for

physicians and other health care providers who treat Medicare beneficiaries. These fees shift millions of dollars in program administration costs from the government to the physicians and other "users". According to the Administration, if Congress fails to approve the new user fees there could be massive claims processing backlogs and slow-downs in Medicare contractor operations.

The proposed new user fees include:

- Subtracting \$1 from payments on any claim that is not submitted electronically.
- Charging providers \$1 fee for submitting duplicate or unprocessable claims.
- Charging providers \$100 to enroll in Medicare initially, and \$25 to reenroll. (There would be a mandatory reenrollment every five years for physicians.)
- Fees would be imposed on home health agencies and skilled nursing facilities for certification and recertification surveys.
- Medicare+Choice organizations would be charged for registration and annual renewal costs.

Despite organized medicine opposition, this provision has not been removed from the budget proposal. Individual physicians who are concerned about the possible imposition of user fees should contact their federal legislators. Congress should be encouraged to appropriate the full amount needed for 1999 and reject the user fee proposal. CMS contact: Marilyn Rissmiller, CMS Health Care Financing Department, 303-779-5455 or 800-654-5653.



Millennial, RMHMO Ink Letter of Intent

Two homegrown Colorado health-care organizations have come together with a shared mission that they say is unique in the world of managed care: putting patient care first.

Millennial: Colorado's Physician Alliance, representing more than 1,600 doctors throughout Colorado's Front Range region, signed a letter of intent to contract with Rocky Mountain HMO, a Grand Junction-based company. The contract is slated to go into effect January 1, 1999.

According to Dr. Gary Gaede, chairman of Millennial's contracting committee, Rocky Mountain HMO is the ideal partner for Millennial's vision of making patient care the number-one objective of managed care.

"Rocky Mountain HMO is a nonprofit organization developed by Coloradans for Coloradans; not surprisingly, they consistently rank first in patient satisfaction surveys among health plans in the state," says Gaede. "During their 24 years in business they have demonstrated their dedication to quality patient care and forming true partnerships with Colorado physicians."

Rocky Mountain HMO President and CEO Mike Weber says the Millennial's large physician panel and geographic distribution, when combined with the HMO's other strategic partner, Colorado Physicians Network, will significantly enhance their Front Range presence.

"We're excited about Millennial's ability to help us serve members throughout the state, as well as their commitment to quality

care. For us, patient care is always our top priority; we believe Millennial is the perfect partner for us and for Colorado patients."

Both groups say that this partnership is the solution to many of the problems that have plagued relationships between physicians and HMOs of late. They claim that the key is putting patient care first in the contracting process—that is, both sides agreeing on what patient care realistically costs, then building a financial relationship on top of that. Gaede refers to this process as building a contract "from the bottom up."

"Many health plans start from the top down," says Gaede. "They set premium price for the patient or employer to pay, take whatever profit they want off the top, then give the leftover amount to the physicians to provide actual patient care. The problem is that amount is often not enough to provide quality care."

Weber adds that, in addition to providing enough funds to physicians for quality patient care, Rocky Mountain HMO agrees with Millennial's vision of giving physicians greater control over the delivery of health care.

Using the clinical information gained through paying claims will allow Millennial to improve patient care in such areas as developing practice protocols, outcomes studies and disease-state management programs. These efforts toward improving clinical outcomes are also one of Rocky Mountain HMO's main interest. With the combined information of the eight physician groups involved, Millennial will now have a

large enough patient base to research and develop programs based on Colorado data, and not rely so much on data derived from other populations.


Millennial is made of eight physicians groups located along Colorado's Front Range. Communities and physicians groups represented in Millennial are Aurora (Aurora Associated Physicians), Boulder (Boulder Medical Center), Colorado Springs (Physician's Network of Colorado Spring), Denver (Colorado Associated Primary Care Physicians, Focus Health Services, South Metro Physicians), Greeley (Preferred Physician Network) and Pueblo (Southern Colorado Clinic).

With their first contract in place, Millennial is working to secure agreements with one or two more health plans in the state before year's end. Gaede says this will be enough to secure Millennial's position in the market and allow the group to prove its strengths to patients, employers and health plans.

"We've made it clear from the beginning that we weren't interested in contracting with every health plan in the state," says Gaede. "Rather, we want to work with plans interested in forming true partnerships based on trust, sharing information, and allowing physicians, to do what they do best: take care of patients. Rocky Mountain HMO shares these goals; we couldn't be more excited to be partnering with them."

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In 1898, Colorado had been a state only 22 years, and the economy and population base was chiefly agricultural and mineral, which meant that the majority of people were working with their hands in decidedly rural parts of the state.

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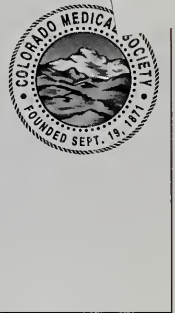
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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by Bill Pierson
Managing Editor

When I was 16 years old I enlisted in the U.S. Navy during WWII. I felt it was something I had to do! When the recruiter discovered my age and asked my parents for their approval, my parents said no. In later years I volunteered for the Army, Navy, Marine Corps and the Air Force Reserve. I eventually served two years in the Army.

How do you explain behavior like that? Well, I felt a responsibility to my country. I was young, virile, and probably thought this was a way to prove my manhood. I lacked responsibility and had little fear.

Later, at the outset of the Korean conflict, I enlisted in the Marine Corps Squad Leader program. This was a 3-year enlistment in which you received the rank of 2nd Lieutenant, and you would see active duty rapidly. I enlisted with a long-time school friend. I was refused on physical grounds; he was accepted. He was a squad leader at Pusan Reservoir and was gut-shot at 24 years of age.

Some years ago (in 1976) it occurred to me that we have this thing all wrong.

Throughout our history we have conscripted young men to serve, to fight and die for this country, thereby dashing all hopes of their life's productivity. If they're not killed, many are mentally or physically maimed and severely disabled, becoming wards of the state. What a horrible waste!

As I ruminated all this, I decided we ought to reverse the whole process: Let the older men serve to protect the future for the younger. The seems more appropriate today.

As we grow older, we lose direction and purpose. We don't seek new challenges, and many look for ways of escaping the ills and woes of old age. Society is even now considering legalizing assisted suicide for those stricken with incurable ills.

Most of this misery occurs after retirement and we start drawing on social security funds or other pension programs. Many are overcome by lassitude and a feeling of uselessness. Others feel they are just a needless burden on their families and on society. Still others have no families

What if we were to change all this by populating our military services with men over 65 years of age; men who have lived a full life and accomplished whatever their career and family goals might have dictated? Granted, they would not look forward to taking up arms, but it would be an adventure for fully matured men. Therein lies another possible plus: because of their languor they wouldn't be eager to fight wars, and if their commanders are of a like mind, we might not have so many conflicts.

In the military, men over 65 would have automatic income, housing, food and clothing, companionship (24 hours a day), no need to prove oneself to others, pre-developed mechanical abilities, shrinking dietary needs and tastes, and **if they have a death-wish** chances are it can be fulfilled by volunteering for hazardous duty.

No more "assisted suicide," no more poverty-stricken elder misfits on the streets; military services run

by men who've had corporate experience and who know how to save a buck; young men who have the opportunity to excel and to raise healthy, happy families, devoting their productive lives to the good of humanity rather than seeking ways to "avoid the draft." Older men will have new opportunities as well; they can put their 65+ years of living experience to work to make this world a better place to live, **and they'll be needed!**

Just imagine, in one fell swoop we could:

- literally do away with FICA and all the political hassles over the Social Security fund.
- reduce Medicare to nearly nothing, having to care only for the female population (we wouldn't deny military service to women, but co-ed barracks for older folks would be tough. There's something funny thinking about "older" men and women running around naked) and those men who were absolutely not fit for any military service.
- reduce Medicaid spending to a dribble, since the military would take those low-income/no-income persons before they had to be on an assistance program.
- give retired physicians an excellent field in which to use their skills and not have to worry about malpractice insurance.
- no concerns over capitation or reimbursement, partnerships, risk pools, operating overhead or patient base.
- and never have to worry about no-pays!

You get the picture, I'm sure.



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October, 1998

Volume 95, Number 10

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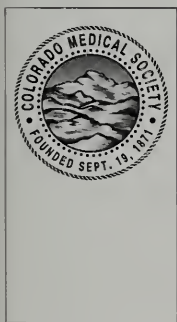
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Cover Story

At a special celebration during the 128th Annual Meeting for the Colorado Medical Society, W. George Shanks was inaugurated as president.

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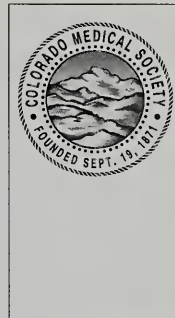


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PRESIDENT'S LETTER



W. George Shanks, MD
President, 1998-1999
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President's Inaugural Address to the Colorado Medical Society House of Delegates, September 12, 1998.

Summarizing the state of medicine in Colorado today, I am reminded of Charles Dickens' "The Tale of Two Cities" and the opening line: "These were the best of times and the worst of times." This theme pretty well sums up the plight of the physicians today, as it did the citizens of Paris so many years ago.

To review the good things in medicine would be appropriate at this time because I think that they are extremely important, yet we tend to minimize and forget them.

What a grand time to be a practicing physician. Just think of the tremendous advances we have witnessed over the past thirty years. Rheumatic heart disease and mastoiditis are essentially non-existent. CAT and MRI have relegated exploratory surgery to the dustbin. Cardiac drugs and surgery have added untold numbers of happy and productive years to an otherwise short and miserable existence. Radiation and chemotherapy have made tremendous inroads against the debilitating effects of cancer. It can honestly be said by all the physicians in this room that the treatment your patient receives today is better than the best offered by anyone anywhere in the world just five years ago! And I am sure that in another three years we will be able to repeat that statement.

Medicine has consistently attracted the best and brightest men and women, superbly educated and trained them. That, coupled with their drive and dedication, has produced a final product which is a thing of beauty envied throughout the world.

In spite of these obvious successes, there is not a lot of joy within the physician community. We are losing our pride and our self-esteem at an alarming rate. Although physicians have never been able to do more for the sick, there is a melancholy that is eating away at our very souls. I am concerned about our ability to adequately care for the sick unless we promote and provide for our own well-being. I am reminded of Luke's passage in the bible -- "Physician, Heal Thyself!"

There are three major players in the delivery of health care. The first and most important is the physician and, as I have already stated, they are strong in both numbers and talent.

The second is the hospital system which has weathered some rather forceful storms and is adjusting to the new realities of outpatient care, but I have some concerns over the conversions to "for-profit status" which potentially could have significant adverse effects in the future.

The third is the financing or lack of such which threatens the survival of the first two. Although the physician and the hospital have traditionally vied for the same health dollar, the real threat to both is the ever-rising administrative costs and profit-taking that is squeezing the system to the breaking point.

It is often said that some of the most important lessons you learn happen in some very unusual places. Shortly after I turned 16, I was invited to visit a farm in southern New Jersey. I had just recently obtained my drivers' license, and at

There are three major players in the delivery of health care. The first and most important is the physician . . .

16 I knew everything about the internal combustion engine, especially when there were four wheels attached. In the barn was a shiny new red tractor that I just had to drive. Asking the farmer for permission, there was a twinkle in his eye when he offered a challenge: If I could start it I could drive it.

This was the start of child-proofing machinery and the proper sequence was to have the gear in

(Continued on following page)

PRESIDENT'S LETTER

(Continued from preceding page)

neutral and the clutch depressed. After a few minutes of tinkering, the tractor roared to life and off I sailed down the rutted road, the deeply cleated tires throwing great gobs of red clay high into the air. I panicked, stepped hard on the brake and the red monster suddenly veered to the left, slid into the ditch and almost rolled on its side. What I subsequently discovered was that the hand-throttle did not automatically return to idle when released. I also learned the brake had a split pedal, with one half controlling the left brake, and the other half controlling the right.

The end result was that I locked the left break, while the right wheel was still at full throttle and I powered the machine right into a ditch.

This lesson was etched clearly in my mind. Whenever I would operate a new or unfamiliar piece of machinery I would always spend time reading the owner's manual. This lesson was overlooked when I wrote an article for *Colorado Medicine* in which I advocated that the physicians be in the driver's seat. I had forgotten to heed my own advice to consult the owner's manual before taking the reins.

The sad truth is there is no owner's manual, and what is written is widely scattered and usually out of date before it is printed. If we are going to drive, we need the owner's manual. Since no manual exists I think this gives us the perfect opportunity to write it.

There is a great crisis in the financing of health care today. The government is having difficulty paying its fair share and is steering the Medicare and Medicaid population into managed care organizations. These organizations proved their worth managing the costs of a health working population, but are now finding it somewhat more difficult delivering the needed care of the poor and aging Americans. But even as the government is encouraging people to join MCO's, they are busy enacting legislation which is under-

mining the basic principles on which HMOs were founded. Is this an end run by the government to destroy what is left of the marketplace and replace it with a federal program?

No matter what your feelings are about MCOs, if they fail the only player left will be the federal government.

The timing is right to become involved. At the AMA Leadership Conference last spring, we had the opportunity to hear President Clinton, Ted Kennedy, Newt Gingrich and Phil Graham. The standing joke at the meeting was that just a few years ago we couldn't even get their chauffeurs to speak to us. This year, they came wanting our help. Can we help? More importantly, will we help? To be effective we need to be better informed. This doesn't come naturally to most of us and we will have to spend the time and effort to educate ourselves.

One of the main hurdles is the managed care contract. Now I don't remember a course in contracts in medical school. I have never had a contract with my patients or with the hospitals where I worked. My only pledge was to do my best. My best is apparently not good enough for most financiers and the contracts very seldom favor either the physician or the patient.

Besides being informed, we have to understand the language and the meaning of their words. There is a vast difference between a physician and a provider; between a covered life and a patient; between a debilitating illness and the "medical loss ratio".

We have to be at the table and constantly remind them of the difference. We have to stand up for the patient, for the sick and infirm who are so extremely vulnerable. These are the people who need our help and these are the very people that most managed care organizations try to shun. These are organizations that tout the miracles of routine mammography but loathe to pay for the treatments of advanced disease.

I am a sickness doctor. I have devoted my life to the study of disease. What really 'swirls my Kilt' is a 15 year old with a ruptured appen-

dix, a 70 year old with obstructive jaundice, a van full of illegal aliens who have just rolled off I-70.

This is who we are and what we do. We must preserve our ability to continue to treat the infirm. Although our ultimate goal may be to be as lonely as the Maytag repairman, and I respect our advancement of preventative services, there is more than enough sickness to go around and we need to be available to provide the care.

So where do we go from here? We have already started with the excellent help of Haavi Morreim and Alice Gosfield. The Board of Directors has unanimously agreed to forego the Interim Meeting of the House of Delegates, and in its place we will have a full day of lectures dealing with the business of medicine.

Today's educational program has also been recorded and will be available for the entire membership. I believe that the practice of medicine has now gone beyond the boundaries of patient care and extended into the world of business. In order to succeed in this new environment we must devote the time and effort. I would suggest that at least 5% of your time should be devoted to the business of medicine, which would include the careful reading of any contract that you sign, to understand more than just the conversion factor. You need to take the time to explain to the insurance companies why you prescribe a certain treatment or drug. If there are too many denials or hassles, then I think for your best health and the best health of your patients you should give serious consideration to deselecting that plan. Until we decide that a poor contract is worse than no contract, the contract will continue to deteriorate. Until we demand that a contract should benefit both the patient and the physician, the only benefit will be to the insurance company. To sign a contract just because we are afraid that our competitor might sign is simply folly. Perhaps our competitor will not sign it either! I also believe that the Colorado Medical Society is the ideal vehicle to spearhead this endeavor. The only way that physicians

will be heard is if we speak with a unified voice. CMS has the broad base of support from both the primary care and the specialists. The health care dollar for the care of the sick continues to decrease as management fees, corporate profits continue to soar. Any help that your specialty society has won is usually at the expense of your colleagues, and is usually short lived.

I view all of this intrusion as just another disease that is affecting the well being of not only my patients but also myself. With my training I know that disease can be conquered. With just a little effort we can harness this beast, we just have to stay focused.

Last year, a couple of weeks before Christmas I happened upon an automobile accident on I-70 just off the Airport exit and only three miles from St. Mary's Hospital. The car had rolled and the only occupant was lying on the road. I rushed over to offer my assistance but this great trauma surgeon was reduced to covering him with a blanket as his life ebbed away. Although I was able to intubate him after the Paramedics arrived he was dead on arrival at the emergency room. As I knelt on the highway amidst Christmas wrapped presents I was thoroughly frustrated. What wonders could I have worked had I only been in the hospital with all the support and backup. It is not too far a stretch to think that, if

things continue on their present course that the emergency room with all its support might not be there for me. With the continual decline of reimbursement to both the hospitals and physicians will there be anyone left to care for the sick? Who will provide the funds for research and post graduate education?

The financial arena is the battle of the future. This will be fought in the boardrooms of the managed care organizations and in the State and Federal health organizations and these are the people that we must get to know. We must take the time to sit down with them and understand both sides of the issues, not just our own. By and large these are extremely bright and well motivated people who believe in what they are doing and believe that what they are doing is right. They seem more than willing to hear our side of the story if it is packaged in a proactive and nonthreatening form. These discussions need to be held in prime time, not at 6:00 am or 8:00 pm. Follow up meetings will probably be required and you need to attend. If we show a commitment to the entire process and not just bellow and roar and leave the details to someone else, I am sure we can move mountains. This is a fight that won't be won in the doctor's lounge. If we wait till it is in the legislature it is probably too late.

Managed care organizations and the Federal Government are recognizing that they are in trouble and I believe that they are ready to seek the help of the physician community. This may be our only opportunity to have our voice heard. Lets make the most of it.

Let me recall the words of one of our former President's David Martz "If not me then whom. If not now then when."

Dr. VanderArk in his presidential speech urged us on with the word "Harambee" which means "lets all get together and push." The recent conflict among physicians is a prime example of the way not to do it. We can never place the patient in the line of fire when we have a dispute with one of the payers. As long as we are divided amongst ourselves we will never accomplish anything.

If viewed just as another disease or illness then we have the tools and expertise to discover the cause and correct it. Although most of us are flying by the seat of our pants we don't have to close our eyes. Although we probably will never be in the drivers seat I am sure that with a concerted effort by all in the CMS we can at least be the navigator. And when all is said and done isn't that the most important seat: to make sure we arrive at the proper destination.

I look forward to serving as your navigator over the next year.

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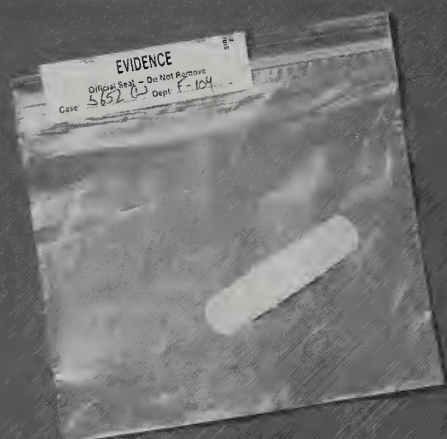


Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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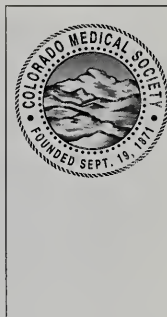
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EXECUTIVE DIRECTOR'S UPDATE



*Sandra L. Maloney
Executive Director
Colorado Medical Society*

The 1998 Annual Meeting, as every one before it, was like no other. This one was still more unusual because it meant change of a different kind.

I was pleased and proud when Dr. VanderArk presented Lorraine Koehn the "Distinguished Service Award". I was saddened, too, because this also marked the end of an era of excellence on the part of our staff that'll be hard to replace. Lorraine announced she will be retiring effective December 31, 1998, ending over 20 years in our Government Affairs Division, and nearly 10 years as Director of that division.

Colorado Medical Society has numerous long-time staffers, but it only has two other 20-years-or-more people on record. One was Harvey Sethman, and the other Donald Derry. You don't get many of those any more, any where, but the record says a lot for CMS: it is a pleasure for many to work for the physicians.

Lorraine has made those years much, much more of a pleasure for others on the staff. She has been positive, supportive, and always there for everyone, no matter what the joy, cause or crisis.

There's some good news (a little bit) that comes out of this: Lorraine will be remaining for January and most of February, up through the final bill filing date, to help with chores at the statehouse. This will give Jerry Johnson, Suzanne Hamilton and Kirsten Spilde a chance to be firmly positioned in their lobbying efforts.

This year's meeting was different in another way: the recognition of Robert Montgomery, of Montgomery, Little & McGrew, the CMS legal representatives.

I feel like I have to say "something" about this man, and that is I am so happy for the House of Delegate's thanks and appreciation to Bob and his associates and staff for the way they have treated CMS. This recognition went much deeper than just saying "thanks" to a law firm. It was the recognition of Robert Montgomery, the individual, who has made our association one of pleasure and friendship rather than "bubble, bubble, toil and trouble" as someone once said. How many times in your life do you get a chance to talk this way about a lawyer? How many times do you find an attorney who refutes all the lawyer jokes? This guy does.

Enough of that! I'm going to get weepy if I keep talking this way. Let's get on with business!

We saw some new and shining lights at this meeting, and we have the officers, directors and staff to keep those lights shining brightly in '99 and right on into the new century. That's right. We now have in place the leadership of CMS that will take this organization right into September, 2000! George Shanks will serve as president til September 18, 1999, and Jack Berry until September, 2000. That's hard to believe, but it's true.

Fasten your seat belts! This is going to be some ride.

"We now have in place the leadership of CMS. . . all the way to September, 2000!"



Sandi Maloney with Lorraine Koehn, recipient of the CMS staff "Distinguished Service Award".



Outgoing president Gary VanderArk, MD, and Sandi Maloney presenting plaque to Robert Montgomery, Esq.

HCFA to move forward with new E&M guidelines

On September 22, 1998 the Health Care Financing Administration (HCFA) announced that they will develop a new set of E & M guidelines to replace the 1995 and 1997 versions now in use. Robert Berenson, MD, Director HCFA's Center for health Plans and Providers, indicated that they will use the "new framework" developed earlier this year as a starting point for the new set of guidelines. Despite strong opposition from the AMA, HCFA has decided that some counting is necessary to assure consistent interpretation of the guidelines by Medicare carriers. As HCFA moves forward on the development of the new guidelines, the AMA has agreed to provide technical advice, through the CPT Editorial Panel, and to coordinate input from state and national medical specialty societies.

Dr. Berenson indicated that prior to final implementation, the revised guidelines will be tested with physicians to assess the burden they impose, whether they are consistently applied by physicians and Medicare carriers, and whether there are changes in physician reporting patterns. HCFA has not set a specific date for implementation of the new guidelines. The AMA indicated that they do not expect that the new guidelines would be implemented before late 1999. CMS will continue to monitor the developments, if you have any questions you can contact Marilyn Rissmiller in the Health Care Financing Department at 303-779-5455 or 800-654-5653, ext. 2428.

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by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

OIG Advisory Opinions: How Do I Get One? Dare I Ask For One?

Advisory opinions from the Office of the Inspector General (OIG) are an outgrowth of anti-kickback and safe harbor legislation. They provide individuals and entities a means of determining whether their own particular business arrangements violate Federal or State law. They offer practitioners and entities the opportunity to avoid costly mistakes and to discontinue arrangements which are considered unlawful by the OIG.

The Medicare Anti-Kickback Statute, which is part of the Social Security Act, provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive "remuneration" in order to induce business reimbursed under the Medicare or State health care programs. The offense is classified as a felony, and is punishable by fines of up to \$25,000 and imprisonment for up to 5 years.¹

The provision is quite broad. The types of remuneration covered specifically include kickbacks, bribes, and rebates, whether made directly or indirectly, overtly or covertly, or in cash or in kind. In addition, prohibited conduct includes not only remuneration intended to induce referrals of patients, but remuneration intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by Medicare or State health care programs.² Whew, that's a lot of stuff.

Since the statute on its face is so broad, concern has been expressed for many years that some relatively innocuous commercial arrangements are technically covered by the statute and are, therefore, subject to criminal prosecution.³

In response to these concerns, safe harbors have been designated which protect various payment and business practices which, although potentially capable of inducing referrals of business under the Medicare and State health care programs, would not be treated as criminal offenses under the anti-kickback statute and would not serve as a basis for a program exclusion under the Social Security Act.⁴

An Advisory Opinion process has been established to allow individuals and entities to find out if their own particular arrangements, or proposed arrangements, constitute grounds for the imposition of civil or criminal sanctions under the Act.⁵ The OIG views an advisory opinion as a means of relating the anti-kickback statute and safe harbor provisions to the particular facts of a

specific arrangement. While safe harbors are intended to create exemptions that apply generally, advisory opinions are intended to address the facts of a particular arrangement. "There are likely to be factors that make some specific arrangements appropriate for a favorable advisory opinion, even in subject matter areas where a generalized safe harbor may be impractical. Thus, we believe that particularized or 'case specific' safe harbor treatment is appropriate where the specific arrangement contains limitations, requirements or controls that give adequate assurance that Federal health care programs can not be abused."⁶ Because advisory opinions are case specific and highly fact sensitive, they are binding upon and may legally be relied upon only by the requestor(s).

Here are the procedures to follow when applying for an advisory opinion:

General Considerations:

- Any individual or entity may submit a request for an advisory opinion. Most requests will refer to health care business arrangements, but they need not.
- The arrangement in question must either be in existence at the time of the request for an advisory opinion, or with respect to prospective arrangements, there must be a good faith intention to enter into the described arrangement in the near future. With respect to prospective conduct, the requestor can declare the intention to enter into the arrangement contingent on the receipt of a favorable advisory opinion.
- The OIG will not provide advisory opinions to persons not involved in the arrangement in question. (Competitors need not apply.)
- The OIG will not provide advisory opinions on hypothetical or generalized arrangements. Safe harbors offer general guidance.
- Requestors who are not individuals are required to disclose certain ownership and control information, so that the appropriate checks can be made to ensure that the matter which is the subject of the advisory opinion request is not under current investigation.

Initiating the Process:

- The requestor must submit a written request. The request must clearly and thoroughly present a complete description of the facts for which an advisory opinion



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm
of Montgomery Little & McGrew, P.C.

*This column contains information concerning topics
of general interest in the medical-legal field. For further
information or help with specific problems, please
contact Montgomery Little & McGrew, P.C.*

is being requested. The request should refer to the sanction authority or authorities (the statute or Act) under which the facts are to be analyzed.

- Submissions must include copies of all relevant documents such as contracts, leases, employment agreements and court documents, as well as descriptions of any other understandings that may affect the documents, and a narrative description of the arrangement.
- The identities of the requestor, a contact person, and all other actual and potential parties (to the extent known) must be provided.
- Two certifications are required from a person with authority: that all of the information provided is true and correct, and constitutes a complete description of the facts regarding which an advisory opinion is sought; and, if the request relates to prospective conduct, that the requestor intends in good faith to enter into the arrangement described in the request. The latter certification may be made contingent upon receipt of a favorable advisory opinion.
- Because these regulations are in flux, it's a good idea (and the OIG suggests you do this) to contact the OIG in inquire (in writing) about the information needed by the OIG to process a request of the type the requestor intends to submit.
- The OIG may be able to send you questions to answer which should elicit the factual information necessary to facilitate an OIG response to the request. There are preliminary checklist and recommended preliminary questions and supplementary information forms which help the requestor and OIG collect the material facts necessary for the analysis.
- The OIG home page is:
<http://www.sba.gov/ignet/internal/hhs/hhs.html>.

Fees Charged:

- Isn't anything free anymore? Apparently not. The Act requires that requestors be charged a fee equal to the costs incurred by the Department in responding to the request. The fee is paid into the general fund of the U.S. Treasury.⁸

- The OIG estimates that the actual cost of processing requests, including salaries, benefits and overhead for attorneys and staff will be near \$100 per hour.
- The processing time will vary according to the complexity of the request and the quality of the submission. A nonrefundable payment of \$250, to cover the initial processing costs, must accompany the request for an advisory opinion.
- The requestor can specify an upper dollar limit on the cost of the advisory opinion. If the costs approach that amount the OIG will contact the requestor for instructions on whether to proceed or withdraw the request.
- Once the requestor has paid the full amount owed for the cost of processing the request, the OIG will release the advisory opinion to the requestor.
- Some advisory opinions will require expert medical or legal analysis which will raise the cost of the opinion. Estimates will be given of this extra cost.

What the OIG Will Do:

- The OIG will promptly examine the request to see if it contains enough information to form the basis for an informed advisory opinion.
- Within 10 days of receiving the request will either request additional information or accept the request.
- The OIG will request additional information later from many requestors.
- Generally, the OIG will issue an advisory opinion within 60 days after the request for the opinion is accepted. However, there may be times when the 60 day time period is tolled, in which event the opinion will not be issued at the 60 day mark.
- The OIG will promptly make a copy of the advisory opinion available for public inspection at the OIG headquarters and the DHHS/OIG web site.
- Unless otherwise exempt from disclosure (such as documents containing trade secrets, and privileged and confidential commercial or financial information), the documents submitted to the OIG and the internal government documents related to the opinions will be available as permitted by the Freedom of Information Act.
- An advisory opinion can be rescinded in limited circumstances, as when the OIG learns after the issuance of the opinion that the arrangement in question may lead to fraud and abuse.
- Unless the OIG establishes that the requestor failed to provide material information in its submissions to the OIG, the requestor would not be subject to OIG sanction for actions it took prior to the notice of rescission, if the requestor acted in good faith reliance on the advisory opinion.
- An advisory opinion issued under this process is legally binding on the Department (including the OIG) and the requestor, but only with respect to the specific conduct of the particular requestor. Third parties are not bound by the opinions, nor may they rely on them. Remember: advisory opinions, unlike the safe harbor regulations, cannot be applied generally.

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- The receipt of an advisory opinion regarding a certain arrangement does not totally prevent the government from commencing an action against a party to the arrangement where, for example, a requestor failed to disclose a material fact.

Dare I ask for an Advisory Opinion? What if what I'm already doing is illegal? Have I just admitted to a violation or a crime? Am I better off not even asking?

- **Answers:** That's a judgment call; You will find out; Probably; and, I wouldn't say that.
- Clearly, the best plan is to submit a request before entering into an arrangement that would or could raise questions under Medicare, State health care programs, anti-kickback statutes, or safe harbor provisions; that is, submit a request concerning a "prospective arrangement," not an on-going arrangement. Rule-makers anticipate that most requests will involve business arrangements into which the requesting party intends to enter, not arrangements they are already participating in.⁹
- What if it's already too late for that? Have you just handed the OIG an admission on a platter? The truth is that we do not know precisely what happens when a request is submitted and it turns out that the on-going arrangement violates anti-kickback laws and is not entitled to safe harbor status.
- The Health Insurance Portability and Accountability Act of 1996, which sets up the advisory opinion process, contains no guidance for the way on this point. Significantly, there are no immunity from prosecution, or give-the-guy-a-break provisions as to on-going arrangements which are the subject of a formal request for advisory opinion.
Unanswered is the question of whether the fact that a party seeks an advisory opinion about an on-going arrangement, may be introduced by the requestor as evidence of a lack of knowledge (knowingly) or intent (willfully) to violate anti-kickback laws (elements necessary for criminal penalties).
- Our best guess is that submitting a request concerning an on-going arrangement could expose you to sanctions for past violations. Reading the rule, there is no reason to believe otherwise.
- There are a couple of rules about the admissibility of

evidence concerning advisory opinions: (1) The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A or 1128B of the Act. (2) An advisory opinion not issued to a person may not be introduced into evidence to prove that person did not intend to violate the provisions of sections 1128, 1128A or 1128B of the Act.

- Logically it appears that determining the OIG's opinion with respect to an on-going arrangement would not help as to past violations, but with termination of the unlawful arrangement, would prevent future violations and the imposition of more serious sanctions.

The statutes and rules governing the advisory opinion process are long but clearly written. The process can be expensive, but probably less expensive than the penalties and sanctions permitted under the law for violations. It sure makes sense to ask before climbing out onto a limb.

References

1. 42 CFR Part 1008, Supplementary Information, referring to Section 1128B(b) of the Social Security Act (42 USC 1320a-7b(b)). Federal Register: February 19, 1997 (Volume 62, Number 33) Rules and Regulations; Pages 7350-7360.
2. Id.
3. Id.
4. Id.; 42 USC 1320b(b); 42 USC 1128(b) (7); 42 USC 1320a-7(b) (7).
5. Id., referring to Sections 1128, 1128A or 1128B of the Act.
6. Id., at p. 7351.
7. Id.; Space does not permit a detailed description of the procedural steps. You should consult the regulation at Federal Register, February 19, 1997 (Volume 62, Number 33) Rules and Regulations; Pages 7350-7360.
8. See Section 1128D(b) (5) (ii) of the Social Security Act (42 USC 1320a-7b(b)).
9. 42 CFR Part 1008, Supplementary Information, referring to Section 1128B(b) of the Social Security Act (42 USC 1320a-7b(b)). Federal Register: February 19, 1997 (Volume 62, Number 33) Rules and Regulations; Pages 7350-7360 at 7357.

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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

15th Annual Santa Fe Colloquium on Cardiovascular Therapy - sponsored by American College of Cardiology

October 8-10, 1998
Eldorado Hotel
Santa Fe, New Mexico
Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

Medicine in the Rockies

October 17-18, 1998
Cheyenne Mountain Conference Resort
Colorado Springs, Colorado
Contact: Erma Francois
(719) 776-5184 or ErmaFrancois@centura.org

The Association of Managed Healthcare Organizations 1998 Fall Forum

October 11-13, 1998
J.W. Marriott Hotel
Washington, DC
Contact: Elisa Ricciuto
1-800-642-2515 or www.amho.org

Update and Review of Internal Medicine 1998

October 11-16, 1998
Marriott Hotel
Albuquerque, New Mexico
Contact: Dorrie Murray
(505) 272-3942

Communicating Expectations: Patients & Physicians

October 21, 1998
Holiday Inn Denver Southeast
Denver, Colorado
Contact: Mary Fletcher
(303) 695-3399 or mfletch@cfmc.org

Physician Finance University - sponsored by Paramount Physician Network, Century Capital Group & SKB Business Services

October 22 & 29, 1998
Doubletree Inn
Aurora, Colorado
Contact: Tracy
(303) 355-9050

The 30th Annual Cardiovascular Conference at Snowmass

January 18-22, 1999
Snowmass Conference Center
Snowmass, Colorado
Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

Clinical Diabetes & Endocrinology

January 24-28, 1999
Snowmass Conference Center
Aspen/Snowmass, Colorado
Contact: Donna Loy
(303) 789-9682 or 1-800-421-3756

Ski & CME Midwinter Conference, sponsored by Colorado Society of Osteopathic Medicine

February 21-26, 1999
Keystone Lodge & Resort
Keystone, Colorado
Contact: Patricia Ellis
(303) 322-1752 or (800) 527-4578

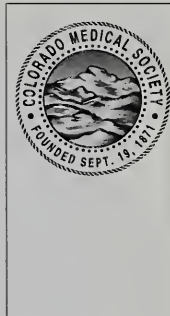
The 6th Annual Echocardiographic Workshop on 2-D & Doppler Echocardiography at Vail - sponsored by American College of Cardiology

February 22-25, 1999
Vail, Colorado
Contact: Registration Secretary, Extramural Programs
1-800-253-4636 ext. 695

Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

CONGRATULATIONS. . .



.... to **Ms. Katie Propst of Sterling, Colorado**, the winner of the Senior Division of the State Science Fair held in April at Colorado State University.

Katie was awarded a Certificate of Recognition and a check for \$100.00 from Colorado Medical Society. She and her parents made the 6 hour trip from Sterling to Steamboat Springs so that attendees at CMS' Annual Meeting could see what this young lady has already accomplished before graduating from high school. Her parents, Ted and Penny Propst, brought her to Steamboat Springs to display and receive her awards from the House of Delegates.

Katie does not have her future planned completely, but she looks forward to more work in the field of natural sciences, and that may include medicine.

The Colorado State Science Fair has been supported by the Colorado Medical Society or (as in the past eight years) the Colorado Medical Society Educational Foundation. This year the Foundation gave the Science Fair \$1,000.00 in support. CMS physicians have been active in some manner in the Fair since the 1950's.



*Above—Katie catches a moment between discussing her science project, **Bacteriophage Therapy: A Possible Alternative Treatment For Bacterial Infections?** Katie is well-rounded with many and varied interests outside her study of sciences.*



Katie Propst (c) of Sterling, Colorado was the winner of the Senior Medial Science division of the Colorado State Science Fair. Katie is a senior at Merino High School. She was caught talking with Dr. George Shanks (L) incoming president of CMS, and Dr. Joe Bonelli of Sterling. Katie displayed her project at the CMS Annual Meeting in Steamboat Springs, September 11-13, 1998.



Guidelines - A short history

Grant E. Steffen, MD
Medicare Director

* "This carrier" as used in the following article refers to Blue Cross-Blue Shield of North Dakota, the Medicare carrier.

"Physicians, not their staff, should learn to use these guidelines. . ."

In 1992, the American Medical Association's (AMA) CPT manual published the new evaluation and management codes; CPT codes 99201 - 99499. These replaced the old codes; CPT 90000 - 90699, which had never been adequately defined. The CPT defined the new E/M codes by history, examination, and decision-making, each of these three elements having four levels of complexity. Because these new codes were (and remain) complex, Health Care Financing Authority (HCFA) did not apply their definitions to the Medical Review process, but allowed the physicians three years to get acquainted.

Thus, in 1995, HCFA and the AMA published a 16-page book of guidelines to the E/M codes. This carrier* sent a copy to all physicians and, in early 1995, presented about 40 workshops across the state in an attempt to acquaint the physicians and their staff with these codes and their specific documentation requirements. This carrier began to use these guidelines for chart review in late 1995. However, the guidelines contained a cryptic phrase where it defined a comprehensive examination as either "a general multi-system examination or complete examination of a single organ

system." This single organ system examination was not defined, leaving both physicians and reviewers with a less than complete set of guidelines.

However, the AMA, HCFA, and the specialty societies began work on defining ten single system comprehensive examinations. These were published in a 49-page document, and sent to all physicians in late 1997. For a combination of reasons, certainly including the fact that HCFA began to focus on Fraud, these guidelines got the attention of the physicians who, through the AMA, attacked these guidelines claiming that they were too complex and that they placed an unnecessary documentation burden on the physicians.

This attack prompted the AMA and HCFA to re-assess the guidelines, a process that continues to the present. HCFA will probably drop the single-system examination concept, liberalize the history requirements, and simplify the decision-making definition. Please understand that this last sentence is a prediction, and that the final form of the E/M guidelines is not yet set. This carrier believes that the final form will be published in late 1999 or early 2000.

In the meantime, this carrier, when it reviews clinical records for documentation, has been instructed to use either the 1995 or the 1997 guidelines, whichever gives the highest level of code. It urges all physicians to review (or view for the first time!) these guidelines. While this carrier has found that the majority of visits that are incorrectly coded are coded too high, still a

significant number are coded lower than the documentation would allow. **Physicians**, not their staff, should learn to use these guidelines both to avoid the loss of income from undercoding and from the unwelcome and often painful chart review that discovers overcoding and leads to a refund check.

Audits of E&M Coding continue to be a part of HCFA's plan.

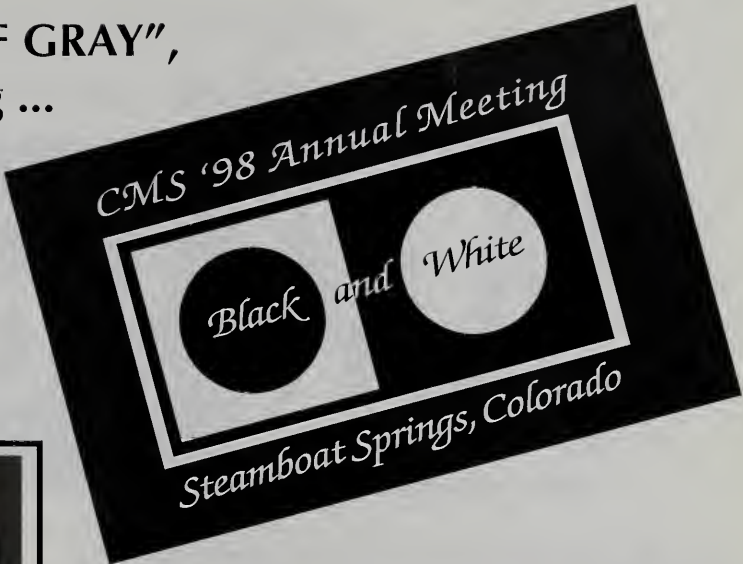
No matter what form the E/M Documentation guidelines may take, they will play an important part in the goals of HCFA's Program Integrity:

- Pay claims right the first time
 - Reduce the error rate to 5% by 2002.
- The 1997 financial audit report showed HCFA made "improper payments" in the amount of \$20.3 Billion. (This equates to an error rate of 11%.) Of this amount HCFA attributes 40% to problems related to physician documentation. In Colorado the preliminary results of the pre-payment E & M audits by the Medicare carrier confirm there are problems with the documentation. Of the E & M codes reviewed 41% were paid as billed, 46% were downcoded and 13% were denied. Although these results are based on a very small sample, they do reinforce the need for a better understanding of the documentation requirements. That is one of the reasons CMS will begin a series of educational articles on E & M documentation next month. If you have questions, contact Marilyn Rissmiller at CMS at 303-779-5455 or 800-654-5653, Ext. 2428.*

For the theme,
 "BLACK & WHITE AND SHADES OF GRAY",
 it was an extremely colorful meeting ...



Outgoing President Gary VanderArk, MD, presenting the CMS Certificate of Service to John L. Lightburn, MD, CMS Historian.



Robert Sawyer, MD, outgoing chairman of the COMPAC Committee, presenting Government Affairs Director Lorraine Koehn with a remembrance of her 20 years service to the committee.



Dr. George Shanks and his lovely family.

There were many activities at the 1998 CMS Annual Meeting, held at the Sheraton Steamboat Resort & Conference Center in Steamboat Springs. We were able to capture just a few memories on film ...but these are not to say that all was play and no work. Evaluations of the meeting, overall, were good to excellent, and the jury's still out whether CMS will return to Steamboat yet another year.

CMS and the CMS Alliance worked hand-in-hand to present one of the best-liked series of programs as we've seen in years. The Alliance co-chair persons, Leslie Nathan and Susan Forester also delivered a year-end report on Alliance activities that will be a tough act to follow. The Alliance joined forces with COMPAC to host a luncheon for the candidates (Colorado Attorney General). The luncheon was well attended.

In addition, the Alliance presented the educational program, "The Medical Marriage: A Couple's Survival Guide," featuring Wayne and Mary Sotile. Frances Weaver, NBC's Today Show Seniors Editor, was also featured in the Alliance program.



New members of the "50 Year Physicians" club are presented to the House by Vice Speaker Sherri Laubach, MD (c). From l to r, Drs. Laurence Currier, Del Stigler, Jesse Humphries, Roy Bartee, and Howard Bess.



Gathering of the past (presidents), Dr. M. Ray and Mrs. Lynn Painter, Phyllis VanderArk and Dr. Gary VanderArk. The load is lifted.

... and even more color!

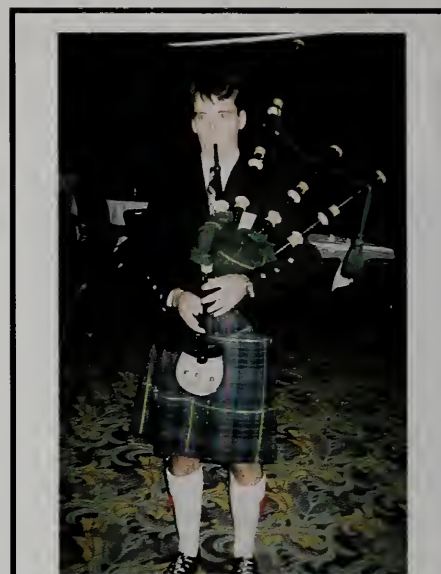
AM 98



Dr. Haavi Morreim (l) and Alice Gosfield, featured speakers in the educational program were both exceedingly well received. Their subjects were medicine and ethics and managed care... how they all fit (or don't fit) together.



Most of the meeting's work was done by Saturday night at the Presidential Inauguration. CMS staff members (l to r) Geneva Pearman, Marilyn Rissmiller, Debbie Jones, Sandi Maloney and Edie Register with some beautiful smiles.



Bradley Shanks piped the benediction for his father's inauguration (and also a couple of dances later in the evening).



CMS Staff: Chet Seward with (l-r) Kirsten Spilde, Janet Scardamaglia, Suzanne Hamilton and Suzi Shevell.



Staff's light rendition of the CMS Seal.



First Dance! Dr. & Mrs. John Lightburn wasted no time in getting to the dance floor at the Inaugural Ball. They made a de-Light-ful couple.

COLORADO MEDICAL SOCIETY

PROCEEDINGS OF THE HOUSE OF DELEGATES

ANNUAL MEETING 1998

The Colorado Medical Society House of Delegates met at the Steamboat Sheraton, Steamboat Springs, Colorado, September 11-13, 1998 and took the following actions:

REFERENCE COMMITTEE OF THE 1998 ANNUAL MEETING

Adopted a Resolution requesting the Colorado Medical Society to pursue appropriate legal action to facilitate timely payment of insurance claims.

Referred a Resolution requesting study of the creation and efficacy of clinical guidelines and practice quality indicators by the Colorado Medical Society.

Referred a Resolution requesting the Colorado Medical Society to study the issues of continuity of patient care within medical groups, and to create a model patient notification letter.

Adopted a Resolution requesting the Colorado Medical Society to introduce legislation addressing termination without cause in physician contracts and application for physician membership in closed panels.

Adopted a Resolution to study representation in the House of Delegates.

Adopted a Resolution to update the Colorado Medical Society's Articles of Incorporation.

Referred a Resolution requesting a study of the sale of health-related non-prescription goods from physicians' offices.

Adopted a Resolution to oppose the legalization of marijuana, precluding the legitimate use of cannabis derivatives approved by the Food and Drug Administration.

Adopted a Resolution calling for the establishment of a uniform external grievance review procedure for the members and/or subscribers of all health plans in Colorado.

Adopted a Resolution to ratify a board motion to allow the Colorado Medical Society to add a budget line item to support a full time staff person to handle the activities of the Colorado Medical Society Foundation Board.

Adopted a Resolution to conduct an educational program during the 1999 Interim Meeting in lieu of a House of Delegates business meeting.

Adopted a Resolution to ratify a board motion asking the Colorado Medical Society, in conjunction with Copic and Gadrian, to conduct a study of all issues surrounding physician credentialing, and the possibility of implementing a Colorado Medical Society Website for Consumers.

Adopted a Resolution to support the work of the Coalition for the Medically Underserved and to invite participation in the revision of the draft plan from the Coalition for the Medically Underserved.

Accepted for filing:

- Progress Report - AMA Delegation
- Progress Report - Board of Directors
- Progress Report - Council on Ethical & Judicial Affairs
- Progress Report - Council on Legislation
- Progress Report - COMPAC
- Progress Report - Executive Director
- Progress Report - CMS Education & Research Foundation
- Progress Report - Health Affairs Council
- Progress Report - Organizational Study Committee

COLORADO MEDICAL SOCIETY

DELEGATE ATTENDANCE

128th Annual Meeting September 11 - 13, 1998

Arapahoe

Judy Baack, MD
Roy M Barteel II, MD
Max D Bartlett, MD
Richard B Capek Jr, MD
Andy M Fine, MD
Steven J Gulevich, MD
Milton E Hammerly, MD
Susan L Jolly, MD
Allan B Kortz, MD
George M Kreye, MD
Mark A Levine, MD
Cynthia L Martin, MD
M Herzl Melmed, MD
Peter I Monheit, MD
Michael P O'Leary, MD
Bernard J Powers, MD
Karl Stecher Jr, MD
Richard H Stienmier, MD
Leigh Truitt, MD
Walter B Vernon, MD
Clara L Winter, MD

Aurora-Adams County

Leon S Greos, MD
Angeline D Heaton, MD
Carl E Heaton, MD
Renu Jalota, MD
Robert L Manguso, MD
Miguel A Morales, MD
M Eugene Sherman, MD
Harry S Spaulding Jr, MD
Barry R Sundland, MD
Christopher J Unrein, DO
James P Wilson, MD

Boulder County

Jan F Baumgardner, MD
Alan E Benson, MD
John O Cletcher Jr, MD
Mary E Faini, MD
Mark M Laitos, MD
Herbert S Mooney Jr, MD
Scott L Replogle, MD
Gerald R Rupp, MD
Melvin R Stjernholm, MD
Harry L Wherry, MD
Patrick L Wherry, MD
William J Williams, MD

Chaffee County

Matthew D Burkley, MD

Clear Creek Valley

Richard L Brundige, MD
Chester M Cedars, MD
Richard S Cohen, MD

Clear Creek Valley

Gordon H Fleischaker Jr, MD
John D Glismann, MD
Thomas M Golbert, MD
Joel M Karlin, MD
Jan M Kief, MD
William H Mendez, MD
Howard E Netz, MD
Walter H Oppenheim, MD
Dean L Sadler, MD
Kathleen Y Sawada, MD
M Robert Yakely, MD

Colo Academy of Family Physicians

Claudia B Wyrick, MD

Colo Allergy Soc

Roswitha Moehring, MD

Colo Chap Amer College of Emergency Physicians

Carla E Murphy, DO
Jonathan E Jensen, MD

Colo Chap Amer Medical Directors

William A Solomon, MD

Colo Dermatological Soc

Loren E Golitz, MD

Colo Gyn/Ob Society

Kathryn P Hebenstreit, MD

Curecanti

Lynwood M Hopple, MD

Delta County

Richard A Dysart, MD

Denver

Richard Allen, MD
Hirsh E Barmatz, MD
D G Butterfield, MD
Theodore J Clarke, MD
John E Delauro, MD
Richard P Evans, MD
Glenn T Foust III, MD
William E Haun, MD
David E Hutchison, MD
George E Kandel, MD
David L Kelble, MD
John L Lightburn, MD
Frank J Major, MD
Bonnie McCafferty, MD
Robert D McCartney, MD

Denver

H Andrew Motz III, MD
Nancy E Nelson, MD
W Gerald Rainer, MD
James R Regan, MD
Edward A Rhodes, MD
Robert B Sawyer, MD
Janet E Schemmel, MD
Carol A Stamm, MD
Richard L Stieg, MD
Del Stigler, MD
Terrance J Sullivan, MD
Kathleen K Traylor, MD
Charles M Tuft, MD
Louise D Converse Walker, MD

Eastern Colorado

John E Fox, MD

El Paso County

Francis J Barry, MD
Norman G Cole Jr, MD
Lewis A Crawford, MD
Ken L Curry, MD
William E Emeis, MD
Fred M Feinsod, MD
Edward M Fitzgerald, MD
John H Genrich, MD
David C Martz, MD
Larry A Moore, MD
John B Muth, MD
Peter G Nielsen, MD
Robert T Pero, MD
Sidney D Rubinow, DO
Teresa H Struck, MD
Paul M Wall, MD

Fremont County

Peter J Gamache, MD
Robert D McCurry, DO

Intermountain

Jonathan C Feeney, MD

Larimer County

Thomas J Allen, MD
Cory D Carroll, MD
Michael P Curiel, MD
Edward J Donner, MD
A Bill Kieger, MD
Robert F Marschke Jr, MD
Krishna C Murthy, MD
Robert J Stuart, MD
Robert J Tello, MD
Steven J Thorson, MD

Las Animas County

Douglas M McFarland, MD

Medical Student Component

Benedikt W Kurz
Amy Huong Thu Le
William G Lechuga Jr

Mesa County

Robert S Hanna, MD
Enno F Heuscher, MD
Bronwen J Magraw, MD
Richard A Moore, MD
Verne A Smith, MD

Morgan County

Patrick L Thompson, MD

Mt. Evans

Marjie G Harbrecht, MD

Otero County

Gary E Lane, MD

Pueblo County

Robert L Drake, MD
Thomas K Gaide, MD
Alethia E Morgan, MD
Sharon K Schaefer, MD
James R Valenzuela, MD
William P Wilz, MD

San Luis Valley

Richard L Brownrigg, MD
Michael G Firth, MD

Washington-Yuma County

Christopher B Eddens, MD

Weld County

Kenneth M Olds, MD
James H Peterson, MD
Richert E Quinn Jr, MD
Keith A Rangel, MD
Roy H Shore, MD
John R Welch, MD

Women In Medicine Section

Jennifer Hone, MD

COLORADO MEDICAL SOCIETY
HIGHLIGHTS OF THE BOARD OF DIRECTORS
SEPTEMBER 10, 1998

- A. Copic: Dr. Buckley presented an over-head presentation. The malpractice rates for some specialties will increase slightly for 1999. Some new discount rates will also be implemented for solo practitioners and groups of five physicians or less. These discounts will be variable depending upon the number of consecutive years with Copic, and the number of claim-free years. Copic will once again make monetary distributions (rebates) to their insureds.
- B. CMSA: Donna Foss requested that the board members encourage their spouses to join the CMSA. She also reported that several CMSA will be attending an upcoming AMA conference.
- C. AMA Delegation: Dr. Joel Karlin reported. He stated that the Colorado Delegation is planning to present two resolutions at the AMA Interim Meeting in December. A separate handout was distributed which came from the AMA. In this document, Colorado Medical Society is mentioned for their work with the HMO's and the CMS/Colorado HMO Association Joint Committee. He briefly discussed his work as a member of the AMA Council on Legislation and his work as a member of the Federation Coordination Team (FTC). The FTC has recently established a Website. Their Website address is www.vfed.org.
- D. Medical Executives Group: Donna Foss reported that four of the medical executives attended the national American Association Medical Society Executives meeting in July. In August, they invited Ms. Marilyn Rissmiller of CMS to give them a presentation on the new E & M Documentation Guidelines, and Mr. Bill Pierson and Ms. Janet Scardamaglia also gave a presentation on the activities of the CMS Department of Communications.
- E. Colorado Physician Network (CPN): Dr. Martz was unable to attend this Board meeting, but will report to the House of Delegates on Friday morning.
- F. Colorado Rural Outreach Program (CROP): Dr. Berry reported that CROP has three small communities requesting grants. There is an aggressive rural fund raising effort underway at this time.

The next CMS Board meeting will be held on November 20, 1998 at the Colorado Medical Society offices.



Ballot initiative #19 is entitled Medical Use of Marijuana

The Colorado Medical Society strongly opposes any effort to legalize marijuana. You are alerted to the fact that this issue will appear on the Colorado ballot for the General Election on November 3rd. Ballot initiative #19 is entitled Medical Use of Marijuana and has the following provisions:

- allows patients diagnosed with a serious illness and their caregivers to legally possess marijuana for medical purposes;
- establishes an exception to the state's criminal laws for physicians to provide written recommendations, other than a prescription, for patients to use marijuana for medical purposes;
- establishes a confidential state registry of patients and their caregivers who are permitted to possess marijuana for medical purposes;
- allows possession of two ounces of usable marijuana and six marijuana plants, and provides an exception to those limits if medically necessary;
- prohibits the medical use of marijuana by patients less than 18 years of age except under certain conditions;
- provides that distribution of marijuana by anyone would still be illegal; and
- provides that health insurance companies do not have to reimburse patients for the medical use of marijuana.

Here are some facts about the medical use of marijuana:

There is a 1998 ballot initiative seeking to legalize the medicinal use of marijuana in the state of Colorado.

Smoked marijuana has not been approved by the FDA to treat any disease or condition.

Sufficient studies of smoked marijuana have not been submitted to permit the FDA to determine if the potential benefits of smoking marijuana for specific indications outweigh the known risks associated with the drug.

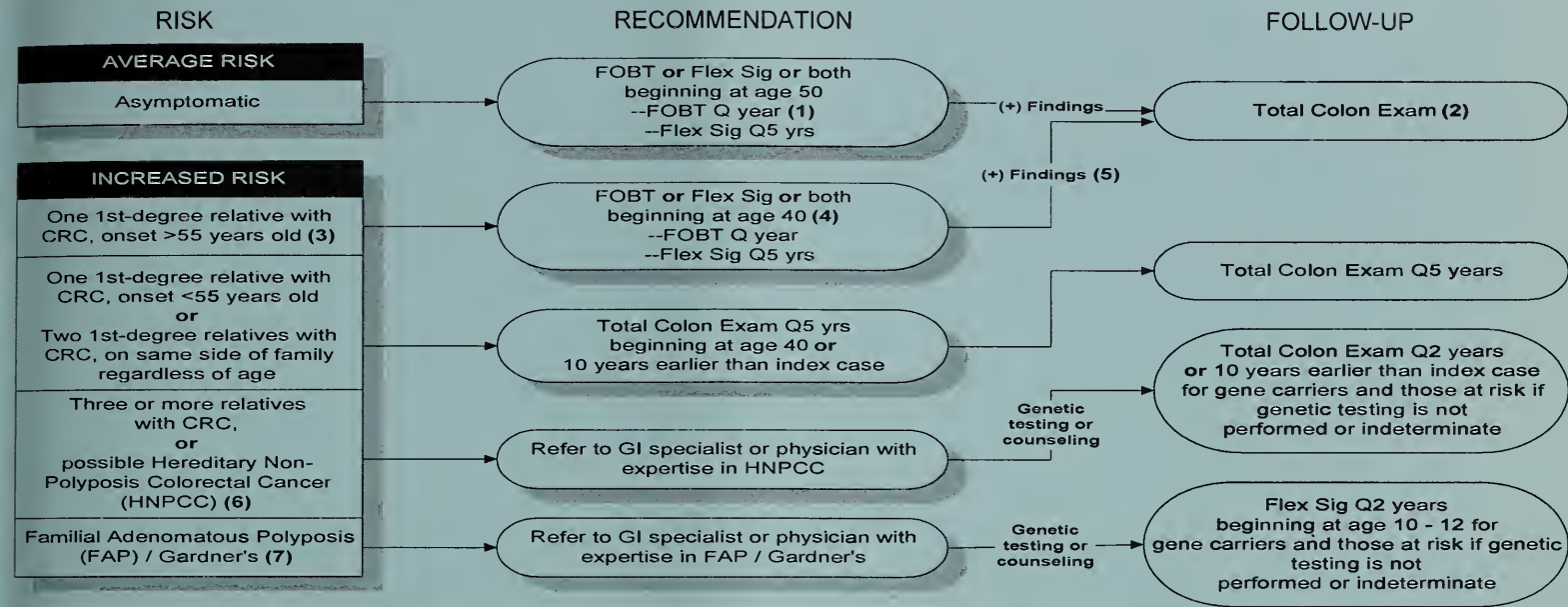
FDA approved drugs whose active ingredients are dronabinol or delta-9-tetrahydrocannabinol (THC) may be legally prescribed by physicians.

The American Medical Association (AMA) Council on Scientific Affairs (CSA), after extensive study, concluded:

"Some of the apparently disparate findings on the medical utility of smoked marijuana may be explained by the use of crude plants of variable potency and the inclusion of both experienced and naïve smokers in the study. The latter feature affects the smoking behavior and efficiency of drug delivery by inhalation. Depending on the condition, research questions to be addressed on smoked marijuana include determining (1) whether it is efficacious; (2) how it compares to Dronabinol®; (3) whether it is beneficial when used in combination with standard therapies or in patients refractory to standard medications; and (4) whether it has benefit primarily in marijuana-experienced smokers. Additional concerns in conducting research

(continued on page 346)

COLORECTAL CANCER SCREENING RECOMMENDATIONS



For the asymptomatic patient, FOBT should be performed on three consecutive stool specimens. Prior to the testing, aspirin and NSAIDs should be avoided for seven days. During the three day testing period, vitamin C, red or rare meat, fresh melons, turnips, radishes, and horseradish should be avoided.

Total Colon Exam includes: Colonoscopy or Double Contrast Barium Enema (DCBE) plus Flexible Sigmoidoscopy. The choice of procedure should depend upon the medical status of the patient and relative quality of the medical examinations. Flexible Sigmoidoscopy should be performed as an adjunct to DCBE. If Colonoscopy does not adequately evaluate the entire colon, DCBE should be performed. Colonoscopy has the advantage to identify, remove, and biopsy suspected tumors and lesions at the time of the exam.

A first-degree relative is defined as a parent, brother, sister, or child.

The American Cancer Society recommends flexible sigmoidoscopy and FOBT for screening of this group. However, either or both tests are recommended by the US Preventive Task Force based on the scientific evidence available.

A positive finding represents adenomatous or villous polyps or adenocarcinoma. Hyperplastic polyps do not require further follow-up unless other risk factors are present.

HNPCC, also known as Lynch Syndrome I, is an autosomal dominant inherited trait that can lead to adenomatous colon polyps and colorectal cancer. The Amsterdam criteria define this genetic syndrome as: Three or more relatives with CRC, or colorectal cancer involving at least two generations, or one or more cases of colorectal cancer diagnosed before age 50 with one being a first-degree relative of the other two. A referral should be made to a physician with expertise in HNPCC for genetic testing and counseling.

Familial Adenomatous Polyposis (FAP) / Gardner's Syndrome is an autosomal dominant inherited trait that can lead to adenomatous polyps and colorectal cancer. A referral to a physician with expertise in FAP for genetic testing and counseling should be considered.

Note: These clinical guidelines are designed to assist clinicians in the management of screening patients for colorectal cancer. The guidelines are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition.

600 Grant Street Suite 700 Denver, Colorado 80203-3525 303-813-5329 Fax 303-860-8774

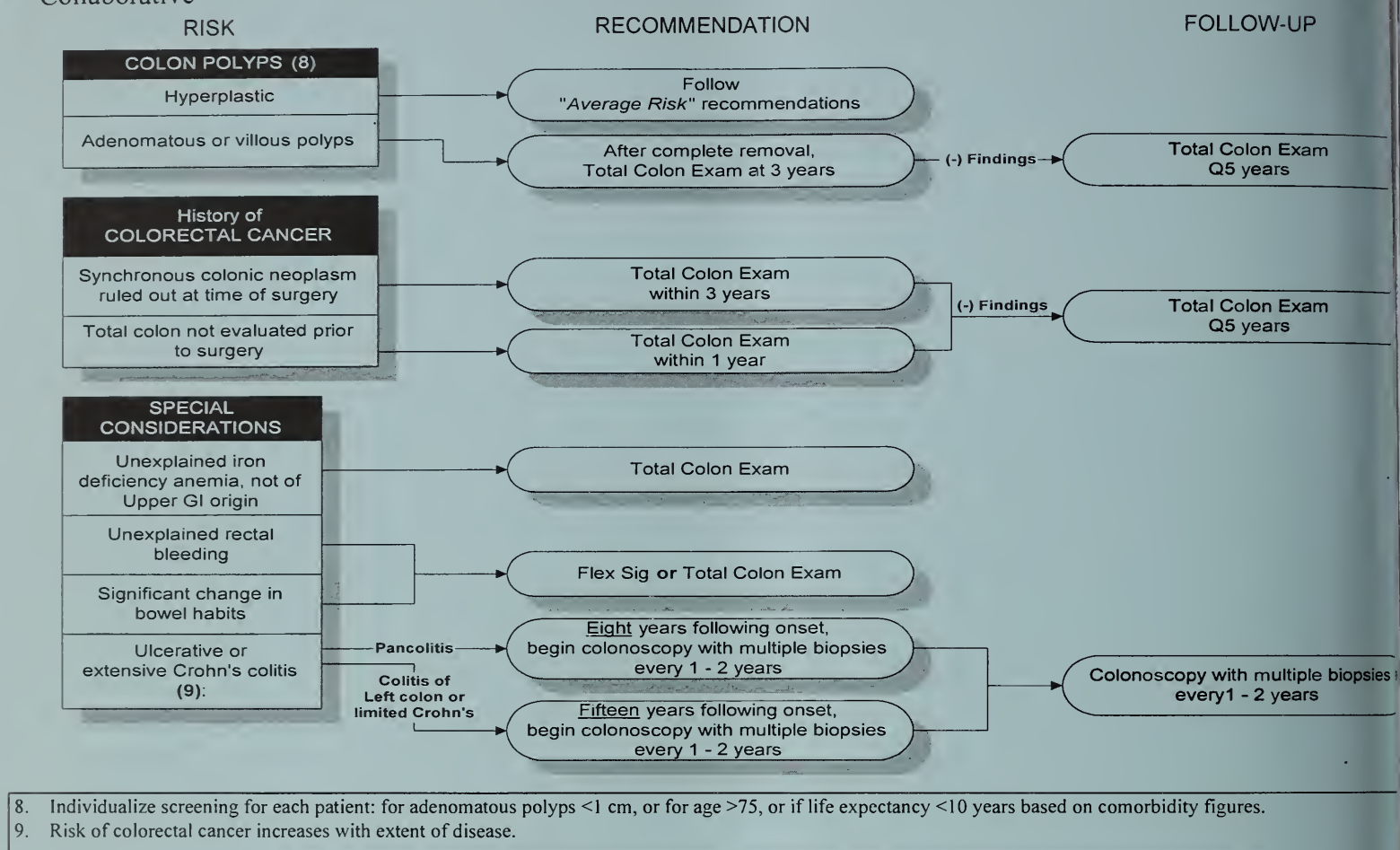
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COLORECTAL CANCER SCREENING RECOMMENDATIONS



Note: These clinical guidelines are designed to assist clinicians in the management of screening patients for colorectal cancer. The guidelines are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition.

600 Grant Street Suite 700 Denver, Colorado 80203-3525 303-813-5329 Fax 303-860-8774

Dear Reader:

Please take a few minutes to complete this survey so that we may serve you better.

- Prior to reviewing the Colorectal Cancer Screening Guideline in this issue of Colorado Medicine, were you aware of the new recommendations for colonoscopy for high risk patients?
 - ☐ Yes
 - ☐ No
 - ☐ Unsure
- Do you want to receive more clinical guidelines?
 - ☐ Yes, definitely
 - ☐ Yes, probably
 - ☐ No, probably not
 - ☐ No, definitely not
 - ☐ Unsure
- What is/are your preference(s) for receiving new recommendations in the form of clinical guidelines? (Check all that apply.)
 - ☐ meetings
 - ☐ e-mail
 - ☐ Internet
 - ☐ journal article (please specify)
 - ☐ health plan newsletter
 - ☐ Web Site
 - ☐ direct mail
 - ☐ other (please specify)
- What written format(s) for clinical guidelines is/are most useful for you? (Check all that apply.)
 - ☐ journal article
 - ☐ one-page summary
 - ☐ pocket handbook
 - ☐ electronic
 - ☐ 3-ring binder
 - ☐ algorithm
 - ☐ other (please specify)
- Specialty:
 - ☐ Family Practice
 - ☐ Internal Medicine
 - ☐ Other (specify)
- Year of graduation from medical school _____
- County in which you practice _____

THANK YOU FOR COMPLETING THIS SURVEY.

Clinical Guidelines Collaborative



COPIC

COMMENT



by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company

Glad Tidings Indeed

Despite what the title of this article might imply, I'm not writing today about the impending holiday season. I'm writing about the **good news regarding Copic's 1999 rates and distribution...**and about the even better news of a **brand-new discount for physicians in solo practice and in group practices of fewer than five physicians** who are not currently receiving special program discounts.

At its August 27 meeting, Copic's Board of Directors approved **rate recommendations that hold the overall average rate increase at typical limits of \$1 million/\$3 million to only 1.26% for the 1999 policy year.** When you include the full range of limits Copic offers, the overall average rate increase is 2.9%.

Specialties whose rates will **benefit from improved claims experience** include Emergency Medicine; ENT; Family Practice doing Major Surgery; Neonatology; Ophthalmology; Orthopaedic Surgery; Pediatrics; Plastic Surgery; and Urology. There are only a **few specialties in which premium increases are required** by worsening claims experience: Vascular and Thoracic Surgery; Family Practice doing OB; General Surgery; Gynecology; and Neurosurgery.

The Board also approved a **\$6 million distribution** payable in 1999. This marks Copic's **ninth consecutive policyholder distribution** and brings the **total returned to policyholders since 1990 to \$58.2 million.** The 1999 distribution will result in an **effective 13% reduction in Copic's "preferred" premium.** ("Preferred" premium assumes Copic's mature rate, limits of \$1 million/\$3 million, a 10% discount for earning at least five ERS points during the last ERS period, and a 10% discount for participation in the CMS Safety Group.)

Perhaps the most significant decision made at the Board meeting was the **approval of a new discount** for physicians in solo practice or in group practices of fewer than five physicians who are not currently receiving special program discounts. Copic is extremely pleased to be able to offer them a discount that **rewards loyalty to Copic and claims-free experience.**

These physicians will be eligible to receive a **discount equal to 0.25% for:**

- **Each complete year** insured with Copic; and
- **Each current complete consecutive year** with Copic; and
- **Each complete claims-free year** with Copic; and
- **Each current complete claims-free year** with Copic.

For purposes of this discount, "claims-free" means that **no indemnity has been paid** on a physician's behalf in settlement of a closed claim. The maximum discount available from satisfying any single criterion is 3.75% (or 0.25% for each of a maximum of 15 complete years). The overall discount is, therefore, capped at 15% (or a maximum of 3.75% for satisfying each of a maximum of four criteria). *Chart A next page.*

This new discount **directly addresses the requests we've received** from these physicians, who accounted for approximately half of our policyholder base as of December 31, 1997.

Copic's 1999 premiums will take effect beginning January 1, 1999. The new discount will become effective for **policy renewals** occurring January 1, 1999 and later. When you review your 1999 premium with your Underwriter, be sure you take into account all of the **advantages** afforded by your Copic coverage:

- Reimbursement for fraud and abuse and disciplinary proceeding expenses (effective 8/1/98)
- Copic Care long-term care coverage
- Death, disability, and retirement provision (DD&R)
- HIV benefit
- Suspension of premium during illness or disability
- Free tail upon retirement
- Free coverage for retired physician volunteers
- Provider Application Subscription Service (PASS)
- Industry-leading risk management services and programs

The most important **Copic advantage**, however, is our steadfast commitment to serving you. That's how it's always been...and that's how it always will be.

on smoked marijuana are the lack of data on its safety in older patients and in those with serious diseases, especially involving the cardiovascular system. A smoke-free inhaled delivery system for marijuana or THC would be preferred.

THC is moderately effective in the treatment of AIDS wasting, but its long duration of action and intensity of side effects preclude routine use. The ability of patients who smoke marijuana to titrate their dosage according to need and the lack of highly effective, inexpensive options to treat this debilitating disease create the conditions warranting a formal clinical trial of smoked marijuana as an appetite stimulant in patients with AIDS wasting syndrome.

THC and smoked marijuana are considerably less effective than currently available therapies to treat acute nausea and vomiting caused by chemotherapy, although certain patients still do not respond adequately to conventional therapy. Research involving these substances should focus on their possible use in treating delayed nausea and vomiting, and their adjunctive use in patients who respond inadequately to 5-HT₃ antagonists. The use of an inhaled substance has the potential for benefit in ambulatory patients who are experiencing the onset of nausea, which precludes administration of an oral dosage form.

Very limited controlled evidence suggests cannabinoids can modify the symptoms of individual patients with spasticity or dystonia. Considerably more research is required to identify patients who may benefit from THC or smoked marijuana, and to establish whether responses are primarily subjective in nature. A therapeutic trial of smoked marijuana or THC may be warranted in patients with spasticity who do not derive adequate benefit from available oral medications, prior to their considering intrathecal baclofen therapy or neuroablative procedures. Controlled evidence does not support the view that THC or smoked marijuana offer clinically effective analgesia without causing significant adverse events when used alone. Preclinical evidence suggests that cannabinoids can potentiate opioid analgesia and that cannabinoids may be effective in animal models of neuropathic pain. Further research into the use of cannabinoids in neuropathic pain is warranted.

Neither smoked marijuana nor THC are viable approaches in the treatment of glaucoma, but research on their mechanism of action may be important in developing new agents that act in an additive or synergistic manner with currently available therapies."

The Colorado Medical Society has brochures concerning the medical use of marijuana which are available as handouts for your office. Contact Kirsten Spilde at (800) 654-5653, ext. 2413 or (303) 930-0413 to receive copies of this information.

COPIC COMMENT

Chart A

(continued from page 345)

Here's how the new discount at its maximum might affect a typical solo-practice family physician whose practice is limited to office/ambulatory:

1999 "Preferred" premium \$8,603.00
Discount for meeting any one criterion
for one complete year: -\$21.51
(Calculated as .0025 times \$8,603)

15 complete years as a Copic insured .. -\$322.61
15 current complete consecutive years
as a Copic insured -\$322.61
15 complete claims-free Copic years -\$322.61
15 current complete consecutive
claims-free Copic years -\$322.61
Total reduction due to new discount-\$1,290.45

1999 premium net of new discount ... \$7,312.55
1999 distribution reduces net premium by 13%
(0.13 times \$7,312.55) -\$950.63

Total reduction from all sources -\$2241.08

FINAL 1999 PREMIUM net of new
discount and distribution \$6,361.92

EXERCISE YOUR RIGHT



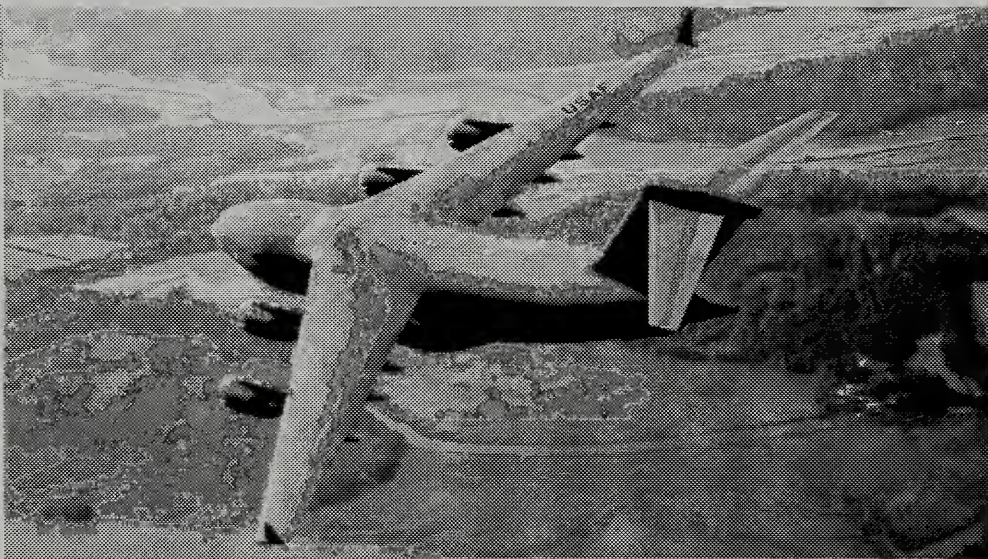
TO VOTE



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MEDICAL CAREER
ABOVE & BEYOND



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However, as a Reservist, your medical expertise can take you around the globe and into real-world scenarios that will take healing above & beyond. Air Force Reserve physician/officers hold a position of special trust and responsibility. Combined with training opportunities in areas such as Global Medicine and Combat Casualty Care, paid CME activities, you will find yourself among an elite group of health care providers. All it takes is one weekend a month and two weeks per year. Feel the pride of doing something above and beyond for your country while adding a new dimension to your medical career.

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APN 25-801-0015





Coalition for the Medically Underserved – Executive Summary

The lack of such health insurance coverage has significant consequences

The Coalition for the Medically Underserved (CMU) grew out of a conference on Caring for Colorado's Medically Underserved, which was convened by the Colorado Medical Society in March of 1997. The Coalition's work has been supported by The Colorado Trust and the Rose Community Foundation. The CMU is composed of representatives from health professional and provider organizations, state agencies, state legislators, foundations, insurers, and business groups. The Coalition's vision is one in which:

By 2007, all Coloradans have unimpeded access to affordable, quality health care and prevention programs. By 2007, Colorado will have a system for health care financing and delivery that ensures that none of the following are barriers to the receipt of medically necessary care: socioeconomic status, language, race, culture, age, gender, geography, insurance status, and distribution of facilities and providers. This vision will be attained through the efforts of the Coalition for the Medically Underserved, working closely and collaboratively with many other groups and individuals.

In order to provide a road map for achieving this vision, the Coalition has developed this document, which describes the problem facing the medically underserved in Colorado and proposes an Action Plan.

The medically underserved are those Coloradans who have difficulty in obtaining adequate health services. Fifteen percent of Coloradans, some 580,000 people, do not have health insurance of any kind and close to that number are underinsured. Eighty percent of uninsured adults are employed. This fact reflects the decline in employer sponsored insurance in Colorado.

In this report we review the dimensions of the problem of inadequate health insurance coverage in Colorado. We note that most of the medically underserved are working, low-income people. The lack of such health insurance coverage has significant consequences: it results in problems in accessing health care when it is needed and this, in turn, leads to poorer health and increased mortality for the uninsured.

There are several misconceptions, or myths, that cloud intelligent discussion of the needs of the medically underserved. This report addresses the most critical myths, namely that:

- 1) Few people are medically underserved.
- 2) The medically underserved are marginal, undeserving members of society.
- 3) Most people without health insurance have chosen to be uninsured.
- 4) The medically underserved can get care when they need it.
- 5) People's health does not suffer as the result of being medically underserved.
- 6) Even if there is a problem, nothing can be done about it.

The number of medically uninsured continues to grow despite a strong economy both locally and nationally. Moreover, there is constant flux between individuals who are uninsured, those who receive care through the Colorado Indigent Care Program, and those on Medicaid, making it difficult to deal with the problem.

As in other states, financing for this population comes via a disconnected set of federal, state and local funding streams including Medicaid, the Colorado Indigent Care Program, Disproportionate Share Hospital funds, Colorado Old Age Pension Health and Medical funds, federal grants to health centers, Child Health Plan Plus (CHP+), Ryan White dollars, and county government program funds.

Beyond these programs, care for the underserved populations both historically and now occurs through the safety net providers; charity care provided by hospitals, clinics, and practitioners; and other community-based programs. These providers include Denver Health, University Hospital, Community Health Centers, local health departments, and the Veterans' Administration Hospitals. But the new era of intense competition and managed care in the health industry is making it harder for these and other providers to continue to provide needed care. They find themselves losing their Medicaid patients to other providers as the number of uninsured patients is increasing. Moreover, the patients they are losing are disproportionately low-cost Medicaid patients, like pregnant women, leaving the high-cost patients, like the chronically disabled, to safety net providers. At the same time, non-safety net providers are seeing fewer uninsured patients because of cost pressures.

Without a coordinated response today to meet the needs of the medically underserved, any significant economic downturn in the future could have a devastating impact on health care access and health status for a great portion of Coloradans. The public views the provision of health care services as

an area in which we have been losing ground as a society. Now is the time for action.

The Coalition has developed an Action Plan with goals for dealing with the problem of the medically underserved. These goals represent a focused vision that will assist Colorado in moving forward with pragmatic, effective changes. They include:

Goal 1:

Achieve health insurance coverage for all Coloradans through a variety of public and private mechanisms by the Year 2007.

Goal 2:

Take interim steps to optimally meet the needs of Colorado's medically underserved, and to phase in affordable coverage solutions for those most in need.

Goal 3:

Ensure that achieving these goals remains a public policy priority.

These goals can be achieved through a variety of objectives. Coalition members developed these objectives through a process of expert analysis. They represent incremental changes that can be made to attain the Coalition's goals:

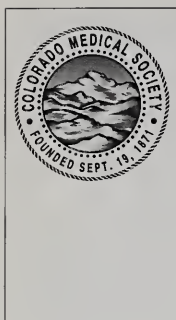
- Clearly identify current gaps and problems in health care coverage for Coloradans.
- Identify practical long-term financing options.
- Develop and implement the components of a system that can assure that all Coloradans have health care coverage.
- Maximize quality and cost effectiveness for all populations in the future system of providing health care for all.
- Implement interim changes to expand the provision of affordable coverage (medical, mental, dental, and pharmaceutical) for all children by January 1, 2000, based upon a formula which uses cost of health insurance as a percentage of income.

- Implement interim changes to expand the provision of affordable coverage (medical, mental, dental, and pharmaceutical) for all adults by January 1, 2005, based upon a formula which uses cost of health insurance as a percentage of income.
- Maintain the safety net in the interim.
- By January 1, 2000, increase the participation of all providers (including physicians, hospitals, managed care organizations, community health centers, health departments, and others) in meeting the needs of the underserved, with particular focus on serving the most underserved areas of Colorado.
- By July 1, 1999, identify and coordinate volunteer provider efforts and community-based efforts in Colorado aimed at serving the health care needs of the medically underserved.
- Maintain the Coalition for the Medically Underserved through the Year 2007 to shepherd, implement, monitor, and update this plan.
- Educate the public and raise awareness about the problems and the needs of the underserved.
- Gain public input to help support and direct Colorado's efforts to achieve health insurance coverage for all Coloradans by the Year 2007
- Secure commitments from other groups to assure responsibility for implementing this plan.

Each of these objectives has specific action steps listed in the body of the document.

These are achievable goals and objectives for Colorado, they are important, and they unite the three principal groups involved in the health care process—patients, providers, and payers—in efforts to address the needs of Colorado's medically underserved.

The Coalition needs your feedback: **fax** comments to Chet Seward at (303) 771-8657, **call** him at (303) 930-0414 or **e-mail** to Chet_Seward@cms.org.



John L. Lightburn, MD
Historian, Colorado Medical Society



"I think to become aware of your life, to examine your life in the best Socratic way is to become aware of history and how little history is written, formed and shaped. I also think that writers in a new tradition, in a new country, invariably, by a kind of reverse twist of irony, become hooded on the past, which in effect doesn't exist and therefore has to be created even more than the present needs to be created."

— Wallace Stegner, *Saturday Review*

WORLD WAR II, the last "good" war

Can any war be good? There are many who would question that concept. This is the first of three, maybe four, articles on World War II and its impact on medicine in Colorado. Good or bad, the war had a profound and lasting impact on Colorado Medicine. These articles will be the beginning of a series devoted to a review of the 20th Century. Readers are encouraged to send in their ideas about events and persons who most significantly influenced the practice of medicine.

This first article will be about the impact of the war on lives of individual members of CMS. World War II was the big event of this century. With few exceptions, it touched the lives of every living being on this planet. Although we were not involved for the first two years of the war, we were concerned as we watched the Nazis overrun Europe and continue to punish Britain with nightly bombing raids. There was no agreement in the U.S. about the potential danger of the German war machine but when the Japanese bombed Pearl Harbor, the threat was clear and the country united as never before. The editor of *Rocky Mountain Medicine* wrote, "Everything is changed. Overnight war was made upon us—and we mean us, for it was made as much upon physicians in the Rocky Mountain states as upon our colleagues in Hawaii or the Philippines . . . but in a way everything seems now more settled—all except those individual decisions as to how best each person and each group can most effectively contribute to a truly 'all out' effort . . . remem-

ber that the possibility that even Salt Lake City or Denver or the Union Pacific Main Line in Wyoming could be bombed." At the suggestion of the A.M.A., the Federal government established a Procurement and Assignment Service for physicians, dentists and veterinarians with Frank H. Lahey, M.D., president of the A.M.A., as chairman of the board of directors. By the end of 1943, 345 members of the society had left their homes and practices to volunteer in the service. Most of these men were in their 40's and some were over 50 years old. They left families with young children. They left practices which had taken 15 or 20 years of diligent effort to establish. For their sacrifice and devotion to their country, here is what their monthly base pay and allowances totaled (if they were married):

Colonel \$489.34
(not many were colonels)

Major \$404.00

Captain \$316.00

First Lieut \$262.67

(the rank for most beginning medical officers)

What a sacrifice these men made.

The United States had not been totally unprepared for the possibility of war. In August, 1940, sixteen months before Pearl Harbor was bombed, the Medical School of the University of Colorado accepted the Surgeon General's request to sponsor Base Hospital #29, later changed to General Hospital #29. In April, 1941, Edward G. Billings, chief of the Psychiatric Liaison Division in the Department of Psychiatry was appointed Director of General

Hospital #29. Ed Billings took his job very seriously. A Lieutenant Colonel in the officers reserve corps, he and his fellow officers went out to Fitzsimons Army Hospital for training in military medicine and discipline. So when war came, Lt. Col., Billings was ready to take command of his crew of medical officers. He was called to active duty on June 22, 1942. The Chairman of his department, Frank Ebaugh, reported for active duty on September 15, 1942 to be neuropsychiatric consultant for the Eighth Service Command in the Western Pacific. They did not care much for each other, so it was fortunate they went their separate ways.

The 29th General Hospital was activated on September 1, 1942 at Fort Meade, Maryland, not far from Washington, D.C. Most, if not all, of the 50 or so medical officers were from the faculty of the medical school; among them were John Foster, Karl Arndt, Edgar Barber, Ivan Philpott, Bill Covode and Frank McGlone. Preparing for an overseas assignment in North Africa, they spent many hours learning tropical medicine, plastic and thoracic surgery, chemical warfare and military procedures. Ed Billings took his men out on the parade grounds to practice marching in formation. He wanted his men from Colorado to look sharp when the Commanding General reviewed the troops. Frank McGlone had a better idea. That parade ground made a better athletic field. So he organized teams in baseball, football, and basketball; ordered the equipment and set up the schedule. He found this much more satisfying than marching in formation.

After a year of training at Fort Meade, they were alerted for overseas assignment in the North African theater. All the supplies and equipment for the 29th General Hospital (including the athletic equipment packed by Dr. McGlone) sailed off for North Africa on August 1, 1943. The medical officers and nurses were to follow two weeks later and planned to board ship on August 15. On August 11, however, those

orders were cancelled. There was high anxiety and the rumors were many until on September 1 orders came to move to Camp Stoneman near San Francisco to prepare for shipping out to the Pacific theater. Travelling across the country, their train stopped in Denver, but nobody was allowed to leave the train. That was a heart breaker. They requisitioned new supplies and equipment. They boarded ship on November 2. Once on board, they were told they would be travelling unescorted to New Caledonia, a large island north of New Zealand. It was a tense and crowded ship and everybody knew the ship was vulnerable to Japanese submarines. They all breathed a sigh of relief when land was sighted on November 21. A truck convoy transported them to a temporary 1,000 bed hospital which had been erected in the Dumbea Valley. The first hospital was a crude affair with no running water or sanitary facilities except deep pit latrines. To prepare for their first patients, officers, nurses and enlisted men worked hard setting up equipment and organizing supplies. You can just imagine Frank McGlone, Ken Sawyer, Ivan Philpott, Foster Matchet, Karl Arndt and Bill Covode wielding hammer and saw under the hot tropical sun (temperatures up to 127 degrees) while nurses set up beds and organized operating rooms. The first patient was admitted two weeks after they had arrived a week later their were 900 patients. John Foster was chief of surgery until June, 1944 when he became commandant of the hospital. Ken Sawyer was assistant chief of surgery, Foster Matchet was chief of orthopedic surgery; Ivan Philpott was chief of otorhinolaryngology; Frank McGlone was chief of gastroenterology and Ed Billings was chief of neuropsychiatry. The list goes on. There were many others equally as important. It was in New Caledonia that Ivan Philpott first tried a new antibiotic call Penicillin.

Across the street the army was constructing a permanent hospital covering 40 acres and room for 5,000 patients. The 29th General Hospital moved into the new facility

in March, 1944. The hospital was a complete general hospital with full medical and surgical services. Sick and wounded personnel were sent in from battle areas such as Guadalcanal and the Caroline Islands. Although they worked hard, there was some time for recreation. Frank McGlone would organize a baseball game, or they could go swimming in a bend in the Dumbea River. Visiting entertainers from Hollywood would put on shows for the patients and staff.

A year later, in May, 1945 the hospital was moved to Okinawa where they set up a new hospital in preparation for the invasion of Japan. The atomic bomb ended the war, so the hospital never became operational. The "boys" came marching home. Over 50 doctors from the Denver area had staffed the hospital.

There are other interesting war stories. Francis Adams, a 30 year old doctor from Pueblo, joined the army reserves in May, 1941 and went into active duty in June, 1942. Along with several other Pueblo physicians from Saint Mary's Hospital were assigned to the 7th Surgical Hospital, which later became the 92nd Evacuation Hospital. Here is how Adams described his experience: "The majority of Pueblo medical officers belonged to this unit. This unit served 8 months in Australia and participated in the D+1 landing on the beach of Hollandia and the D+4 landing Lingayen Gulf on the island of Luzon in the Philippines. It had considerable combat experience. It was under enemy air attack innumerable times and suffered casualties in hand to hand combat." This was strikingly different than the 29th General Hospital.

Fred Brandenburg left his surgical residency in Boston to join the army and after months of training became a Battalion Surgeon in the 377th Infantry Regiment in General Patton's famous 3rd Army. His unit was involved in the drive across France to the Rhine River. The 3rd Army was trying to drive the Germans out of the fortified city of Metz. Brandenburg and his crew of

(Continued next page)

"medics" crossed the Moselle River in boats under cover of darkness. Many men perished when German shells found their mark. The crossing was temporarily abandoned while efforts were made to destroy the German artillery. For a week, Brandenburg and those who successfully crossed were trapped and were running low on food, medical supplies and ammunition. In efforts to reach men who had been injured, he came under fire and there were times that he was not sure he would come out of this engagement alive. Metz was finally taken and they suffered through the bitter cold of that winter as they pursued the Hitler's legions through Holland,

across the Rhine and into the Ruhr Valley. Fred Brandenburg survived it all and returned to Denver to start his surgical practice at St. Anthony's Hospital.

Alexander Freshman left his practice in the Metropolitan Building in Denver on June 23, 1942 to join the 172nd General Hospital as chief of laboratories. Organized in Texas, it ended up in China, several miles outside of Kunming. It had 1,000 beds and was the only U.S. Army hospital in mainland China. The United States was everywhere.

Glen Giffin left his practice in Boulder September 10, 1942 to become a Battalion Surgeon in the 246th Quartermaster Battalion. He was injured in combat and was hospitalized from April 26, 1943 to May 17, 1945. Another Boulder

physician went into the service on July 16, 1942 and was assigned to the 11th Field Hospital where he was chief of an experimental mobile hospital in the Sicilian and Italian Campaigns. These were the mobile surgical units equipped to care for non-transportable injured soldiers. This proved to be so successful that it became the standard for all field hospitals in Mediterranean and European theaters.

Each of the over 300 men had a different story to tell, some exciting and dramatic, some ordinary and mundane, but each with an important role to play in the winning of the last good war. It is easy to think of them as heroes. Next month we will describe how the doctors on the home front did their part.

Seeking . . .

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Challenging, rewarding position.
Malpractice and medical insurance provided.
No call and no weekend coverage.
Four days of work per week preferred.
Loan Repayment Site.

If interested, please send resume to:

Ed Farrell. M.D.
Stout Street Clinic/Colorado Coalition for the Homeless
2100 Broadway
Denver, Colorado 80205

or fax to (303) 293-3977.
Call Ed Farrell at (303) 293-2220 for more details.





David C. Martz, MD
President, CPN

62 was Just a Number

3 months ago, 62 was just another number between 1 and 100. On September 8, 1998, 62 became the most recognized record in the entire history of baseball. Even the fans who can't hit a beach ball 5 feet with a 2 by 4 will always remember where they were when Mark McGwire hit home run number 62.

4 years ago CPN was just 3 letters in the English alphabet. In the next 6 months CPN may become the most discussed concept in recent CMS history. However, whether that be in cheers or jeers is yet to be decided. Hopefully, it will be the former.

We have much to report that is exciting and optimistic in recent months:

1. Our physician membership now numbers over 2500;
2. We have enrolled a total of 7748 participants in RMPC;
3. We have developed physician friendly risk contracts;
4. We have consolidated our physician and hospital base in the Greeley-Loveland area including both the Greeley Medical Clinic and the PHO physicians in a risk contract arrangement with RMPC;
5. A letter of intent has been signed with Millennial which would create a risk arrangement with 1600 physicians in the Front Range in exchange for their commitment to market our product as a top priority;
6. RMHMO has committed to aggressive expansion through CPN in the Front Range as essential to their strategic business plan.
7. The unique 3-tiered product we described at the Interim meeting that combines HMO, POS, and indemnity options is now competitively priced and generating intense interest and response on the Front Range;

8. Over 1500 more lives have been contracted for coverage in the next 3 months, and over 9000 quotes have been requested, likely to result in another 900-1000 new members;
9. Thus, our anticipated enrollment by January 1 is in the range of 10,000—we anticipate break-even economics when we reach 20,000 lives.

On the other hand, we have been faced with some troubling developments recently:

1. California Advantage—like the Floridian Medical Society plan—has declared bankruptcy this summer, emphasizing the complexity of the task we have undertaken;
2. Medicaid losses have been massive and unacceptable, necessitating our withdrawal throughout the Front Range with limited exceptions, pending restructuring of the Medicaid agreements;
3. RMHMO has continued to struggle with economic issues that have been besieging them over the past 3 years, with hope—but no guarantee—of stabilization in the near future;
4. CPN has experienced parallel financial losses in recent months, and has negotiated a repayment plan to RMHMO based on withholds and deferred profitability sharing which both organizations feel is fair;
5. We have re-affirmed our partnership with RMHMO, and recognize our financial viabilities are intricately entwined.

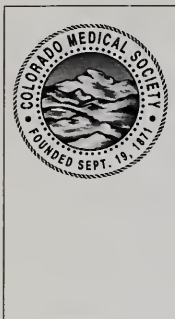
It is not surprising that we should be facing these issues—we have known that our dream involved competition in a nasty environment from the outset. It is, however, our responsibility to respond to the challenges with renewed commit-

ment, that may include:

1. Accepting the reality of slower enrollment and modest withholds to get us through the financial pressures that always occur when membership numbers are small;
2. Stepping forward to speak out when the opportunities arise to champion the unique values to our patients provided by RMPC;
3. Touting RMPC to your patients, friends, and acquaintances;
4. Facilitating contacts with business associates responsible for their employees health care benefits;
5. Striving to provide economical care to your patients consistent with both high quality guidelines AND cost efficiency.

We may be on the threshold of fulfillment of our dream—but the next few months will be most challenging, and we will need your understanding and support as never before. It is still within our power to determine whether CPN will live on and flourish, or flounder and fail. For the present we will concentrate on hitting singles, and leave the home runs to Mark McGwire. But by this time next year we will be either the talk of the town, or all broken down.

To baseball fans around the world, 62 is no longer just a number: this year it represents the ultimate in athletic skill and personal character. To Coloradans, CPN could become far more than mere debris in a world of alphabetic jargon. This is the year it could symbolize the profound difference between "Having a Dream" and "Making it Happen!" But this will require miraculous effort, both from RMHMO—and from ALL of you!



LETTERS TO THE EDITOR

Dear Bill,

I enjoyed your September *Ruminations*, first because they reminded me of myself volunteering for the Air Force at nineteen, and the blanched face of my mother when I came home and told her. I was rejected because of a few high blood pressure readings.

Then I remember my uncle, Dr. Jerome Head, a college teacher of English when he volunteered in World War I. He told his distressed mother "I'm healthy, and not married. Who could better go?" He taught artillery until he convinced the Army to send him overseas.

During the voyage the Armistice was signed, so the greatest danger he and his friends faced was breaking into the bricked-up chambers of French vineyards to find the Champagne hidden from the Germans. Years later, as surgeon and historian, he saw another war wasting our young men. Though I don't believe he actually volunteered, he was serious in suggesting that America call up its older men before taking all our young men from their work, their colleges and their families. He said he could see, and press a trigger, as well as anyone, maybe better.

So your suggestion is more practical than facetious. I suppose it will never fly.

Best wishes,
Thomas Head Coleman, M.D.
Denver, Colorado

Dear Colleagues,

A recent survey of high school students in Denver rated teen pregnancy as the number one problem existing in their community. (Denver Post)

In the U.S., some analysts believe that a population of 150 million people is the maximum number that can live in the 50 states without leading to environmental degradation and reduction in the quality of life. (NPG)

Globally, we approach a total population of 6 billion (on the way to 10 billion next century) in which 25+ percent do not have enough to eat. (McNamara, World Bank)

Accordingly, I think it is time to make control of fertility a priority for every human being. The late David Packard understood this and has made family planning activities the primary beneficiary of his \$9 billion estate.

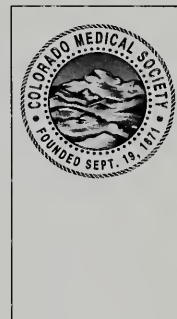
Recently, the first "morning after" pill has been approved for marketing in the U.S. (Associated Press, September 2, 1998). However, I am afraid that the medical profession is appearing to be a stumbling block to personal control of contraception. I believe it is time to make post-coital contraception available over the counter. Appropriate warning labels could be affixed regarding the small but definite risk of thromboembolic disease. According to Planned Parenthood, "1.7 million unintended pregnancies and 800,000 abortions could have been prevented every year that the morning after pills were withheld from U.S. distribution". I believe that physicians should be on the side of patient choice and control of their fertility. Making the "morning after" pill available over the counter would be an important first step.

Sincerely,
Frank R. Purdie, M.D. FACEP

Editor's Note: Dr. Purdie's letter was mailed with a copy of Diane Carman's column from the Denver Post, printed September 15, 1998 entitled Censoring Pregnancy Prevention.

Colorado Medical Society invites its member physicians to respond to articles or letters published in **Colorado Medicine**. Such "Letters to the Editor" will be published, but **must include the physician's name**. Opinions or comments included in such letters are those of the writer and do not reflect the views or policies of the Colorado Medical Society or its leadership. Send letters to: Editor, Colorado Medicine, P. O. Box 17550, Denver, CO 80217-0550.

BOARD OF MEDICAL EXAMINERS



New Rules Adopted

The Colorado Board of Medical Examiners held a public rule making hearing on August 13, 1998. One of the newly adapted rules concerns the maintenance of current licensee addresses for the purpose of mailing various Board correspondence including, but not limited to, formal complaints, renewals and newsletters. As indicated in the rule, a licensee must specifically request an address change in writing. Licensees should be aware that, as in the past, the address used for Board mailings is also the address available to the public.

The rule is effective September 30, 1998.

Inquiring parties may contact the Board office for further clarification at 303-894-7690 or 1560 Broadway, Suite 1300, Denver, Colorado, 80202-5140.

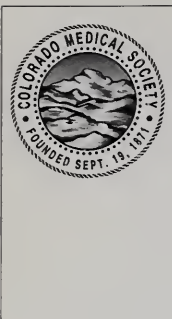
COLORADO STATE BOARD OF MEDICAL EXAMINERS RULES AND REGULATIONS REGARDING THE MAINTENANCE OF CURRENT ADDRESS

Basis. The authority for the promulgation of Rules and Regulations by the Colorado State Board of Medical Examiners is set forth in §24-4-103, C.R.S., and §12-36-104(1)(a), C.R.S.

Purpose. The purpose of this rule is to provide medical Board licensees and staff with clear guidance as to what is a licensee's address of record for Board purposes.

RULE

1. A licensee's address for purposes of sending a "30-Day Letter" pursuant to §12-36-118(4), C.R.S., for purposes of maintenance of address pursuant to §12-36-123(2), C.R.S., for purposes of issuing a formal complaint pursuant to §12-36-118(5), C.R.S., and for all other Board purposes, shall be the mailing address as indicated by the licensee on the application for initial licensure. The Board will thereupon change a licensee's address only upon a clear, explicit, and unambiguous written statement from the licensee or the licensee's agent that the address should be changed. The mere receipt of correspondence from a licensee showing a new address shall not be sufficient to change an address.
2. Thereafter, the licensee's "last address" shall be the address as indicated in the request for the change. In the event that a licensee submits a request for a change of address, but does not indicate between the business and home address where Board correspondence should be sent, the business address shall constitute the address for purposes of this rule.
3. In no event will the Board accept a change of address request which requests the address be changed for some, but not all, communications. Also, in no event shall the Board change the address if a licensee indicates that Board correspondence shall be marked "confidential".

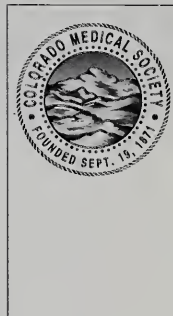


The Department of Regulatory Agencies' Child Support Enforcement Office, will act to suspend licenses as required by law.

Are You In Compliance With Colorado's Child Support Statutes?

If not, you risk losing your medical license. State legislation designed to comply with the federal "Personal Responsibility and Work Opportunity Act of 1996" was passed by the legislature in 1997. Colorado Revised Statute 24-34-107 mandates that the licensing boards under the State Department of Regulatory Agencies shall deny, suspend, or revoke any license when the "division board or agency receives a notice to deny, suspend, or revoke from the state child support enforcement agency because the licensee or applicant is out of compliance with a court or administrative order for current child support, child support debt, retroactive child support, child support arrearages, or child support when combined with maintenance or because the licensee or applicant has failed to comply with a properly issued subpoena or warrant relating to a paternity or child support proceeding." This statute applies to any delinquent parent holding a medical license or physi-

cian assistant certificate. Other licenses which may be sanctioned are motor vehicle licenses, and recreational hunting and fishing licenses. The law also provides for liens against the real and personal property of delinquent parents. The Department of Human Services will soon begin notifying Colorado licensing authorities of licensee non-compliance. The Medical Board, in cooperation with the Department of Regulatory Agencies' Child Support Enforcement Office, will act to suspend licenses as required by law. Please note that suspensions are automatic and the Medical Board has no discretion with respect to the decision to suspend a license. Reinstatements will not occur until notice of compliance is received from the Department of Human Services. Licensees with questions concerning child support should contact Teresa Lawser, Child Enforcement Division of the Department of Regulatory Agencies at (303)894-2900, Ext. 603.



A product of the 1998 Legislature was the passage of House Bill 1062. The purpose of the bill was to effect more timely closure of workers' compensation claims. Where issues between the parties are disputed the bill is intended to ensure timely prosecution of claims for benefits.

The Division of Workers' Compensation IME program was impacted by the bill. In essence, the bill requires the parties to attempt to agree on a physician to conduct the examination so that the process can proceed as efficiently as possible. Only if the parties cannot agree on an examiner can they then apply to the Division to have an examiner chosen through the IME program. At this point, the process then mimics what has been established in the program for the last few years. The Division selects three qualified physicians, the parties can exercise one strike each, and the remaining physician is the person chosen for the review. Charges for the reviews remain the same.

The legislation requires the Division to make its IME physician selection within ten days of the receipt of the application for an IME. Prior rules allowed twenty days to accomplish the selection. Because of this time change and the indefinite start date (the Division's receipt of the application) some changes in the process were necessary. The Division IME staff will call the parties on the fourth business day

after receiving the application and leave the panel physician names either on voice mail or by speaking with someone in the office. The parties then have three business days in which to submit their strikes to the Division. The Division will then select the doctor for the IME and call the results to the parties. Any party that is representing himself may call to get the panel list, and call to make his strike.

These changes can be found in Rule XIV, L., Workers' Compensation Medical Cost Containment Rules. This is where previous IME rules were recorded. These new rules amend the old rules. The IME application form has also been revised to comport with HB 1062. It contains information that is substantially the same as the old form with some format changes for easier reading. The IME Unit and Customer Service have copies of this new form.

For injuries that occurred prior to August 5, 1998, the IME Unit is accepting the old application form or the new form, whichever the applicant prefers. After November 1, the Division will only accept the new form and the new rules will be applied in all cases. This time frame was selected in order to allow participants in the IME system sufficient time to become familiar with the new rules, procedures and forms. Contact Customer Service at 303-620-8700. Contact WC IME Unit at 303-575-8840.

The bill is intended to ensure timely prosecution of claims for benefits.

Who's

WATCHING OUT For You?

From providers to community leaders, researchers to educators, and government officials to citizens, the National Rural Health Association's members seek to improve the health care of rural Americans through advocacy, communications, education and research.

The National Rural Health Association and its members work to overcome rural health care challenges. They focus on reforming and strengthening health care to meet the needs of rural areas. While government funding continues to dwindle, this multi-disciplinary group of health professionals and leaders finds innovative solutions to complex dilemmas.



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For more information, contact the NRHA,
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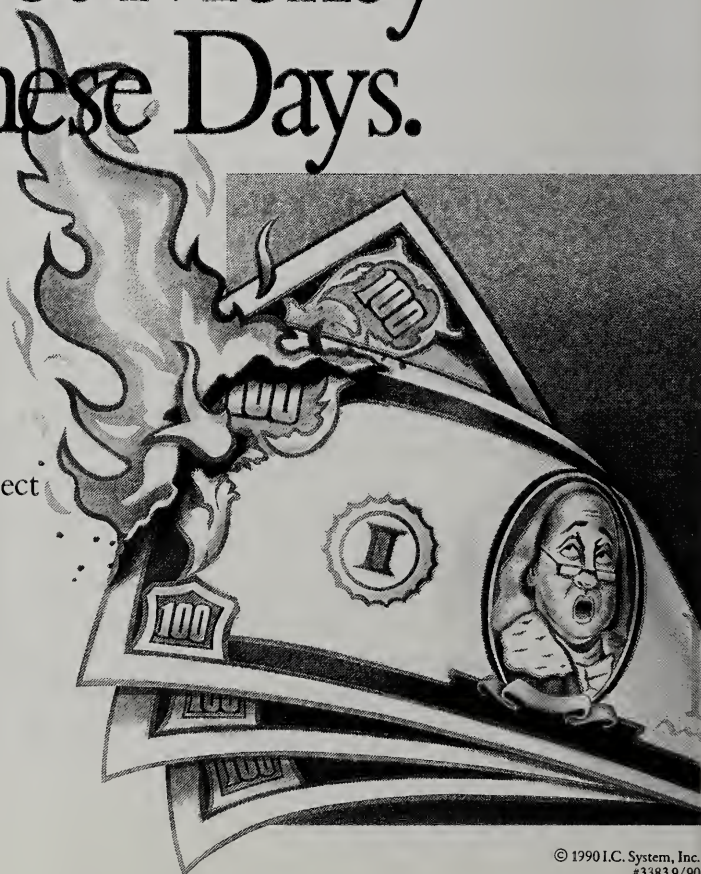
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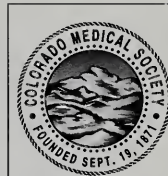
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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

"You'd better learn how to talk to a reporter!"

We have a policy at CMS Communications. It is a policy, even though it may not be written anywhere. I don't remember if it is.

The policy on dealing with general news media inquiries is:

Our office door (in any form) is always open; we'll talk to you if we are in the office, or we will get back to you as quickly as humanly possible any time, any day (except when we are on vacation). All we request of the news media is an equal shot at voicing the organization's side of the question or story. If the news person is looking for

skeletons in our (organization's) closet, we'll be happy to help them look; we want to search them out as well. Colorado Medical Society has long felt this is a healthy pursuit (if you can say that about skeletons) and should contribute to maintaining CMS members as the best physicians.

Certainly, many responses to media questions have to be bland or non-news replies because this organization, like any non-profit professional organization, is governed by many laws and regulations. Good taste and ethical guidelines dictate these non-news answers many times as well. For instance: In September I was asked by a print reporter for a CMS opinion about something that an independent firm or organization was promoting. **My reply:** CMS does not have an opinion. **Reporter:** Why not? **Me:** Because CMS represents over 5,000 Colorado physicians and this organization does not keep book on every one's "opinion" about commercial enterprises and CMS is not about to label anything good, bad or indifferent unless that thing has a direct impact on the quality of patient care.

This exchange went on for about 5 minutes and the reporter was becoming very upset, saying "You're supposed to be the doctor's spokesman, why can't you give me an opinion?" I finally gave up, saying "No matter how long this conversation goes on, the CMS position won't change." I don't understand why they don't understand!

In July, a newspaper reporter called asking some such unanswer-

able question, and I gave him the same reply. "We just don't go around branding things that are not directly involved with patient quality of care."

I then made the mistake of saying, "For your future reference, and this is definitely off the record because I am not to be quoted, etc..." The person replied that "nothing is off the record when you're talking to a reporter". I said "Oh yes, something is off the record when you're talking to me about a critical patient care matter that could only be addressed by a physician." The reporter's reply: "You'd better learn how to talk to a reporter!" I blew my head gasket on that one. I told that reporter to never call this office again!

I don't have any exclusive license on how to represent this organization or, for that matter, any other; I do know the difference between civility, respect, and the outright misuse of a position or title. I am confident that the Colorado Medical Society will always treat reporters, editors, specialty writers or journalists with mutual respect and fairness. I will also respond to their **lack of** mutual respect.

I mention these small incidents only because all CMS members should know that just because you don't see our name or opinion in the news much, it's because the writer or reporter respected our position and kept our name out of an otherwise pedestrian argument or contest.

I can only hope that I know "how to talk to a 'reporter.'"



COLORADO MEDICINE

HS/HSE
UNIVERSITY OF MARYLAND AT
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ember, 1998

Volume 95, Number 11

NOV 18 1998

STACKS
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Transition Workshops
Information for a successful transition

Transition changes

Doing new things

Timelines
key to success

right things at the right times



Colorado Medicaid Program

1998 Fiscal Agent Transition

December 1, 1998

Transition Guide

A reference for Medicaid Providers

The official guide to participation in the
Colorado Medicaid Fiscal Agent Transition

Bring this guide to
the transition workshops



Operative Word: **"Transition"** to the new Medicaid participation effective December 1, 1998. See pg. 380

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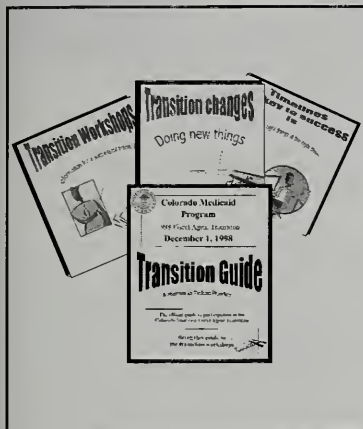
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COLORADO MEDICINE

November, 1998

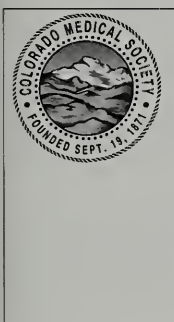
Volume 95, Number 11



Cover Story

Manage care, where are we, where have we come from, where are we going? Thoughts from an expert on the other side of the fence and notes from the front line.

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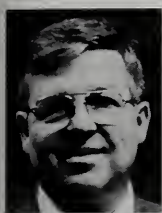
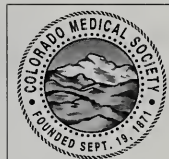


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PRESIDENT'S LETTER



W. George Shanks, MD
President, 1998-1999
Colorado Medical Society

At our Annual Meeting it was decided to forgo the Interim House of Delegates meeting in favor of a full day educational forum dedicated to the Business of Medicine. We will concentrate on the role physicians can play in the evolving health care arena. This will be one of my objectives during the coming year: to help you understand the rules of the game so that we may have a better chance of winning.

As I try to sort out the dilemmas facing health care, I find that one of the major clashes is between the patient and society and identifying where the physician fits in. We have at our finger tips the technology and skills necessary to treat the sick and restore their health and well being. Are we going to stand idly by as these advances are curtailed by the dictates of Wall Street?

As a way of reminding myself of who the real enemy is, I view physicians as an army of foot soldiers and the enemy as diseases, acute and chronic.

One of the cardinal sins of any army is to advance beyond the capacity of its supply lines. Both Napoleon in the 19th century and the Germans in this century forgot this principle and both suffered humiliating defeat at the hands of the Russians. In contrast the Allies (Americans) in World War II recognized the importance of the objective and invested the necessary resources to achieve a resounding victory on the Normandy beaches. Similarly there were no shortages when we restored the Democracy of Kuwait. Do we really value oil more than the health of our citizens?

As the supplies for the sick disappear, some of us have resorted to the time honored tradition of shooting each other, "circle the wagons and fire towards the center." The more adventurous are taking aim at the supply sergeants.

Instead of fighting among ourselves over an ever-dwindling piece of the pie, there are two things that need to be done. The first is to stop the leaks going to the profiteers of Wall Street, and the ever increasing portion allotted to "pseudo medicine."

Even if we stop the leaks, I don't think that the piece of the pie will be sufficient to sustain the fight as we continue to increase our arsenal. Medical advances are costly and we should in no way accept any further cutbacks in our research or graduate education.

To maintain our present funding and increase it in the future we will have to establish better relations with the supply sergeants. Our supply sergeants originate in Congress and filter down through Health and Human Services and the Health Care Financing Authority. They, in turn, contract with the Medicare carriers and the State Medicaid programs. We also have to deal with the local and national managed care organizations. These are the organizations with whom we have to establish a constructive dialogue.

I firmly believe that most of these organizations have very little understanding of the nuances of treating the sick. We need to understand that they have their own agendas and are not at all interested in our whining, or our agendas. We

To maintain our present funding and increase it in the future we will have to establish better relations. . .

need to start the dialogue by trying to help resolve their issues, and in doing so, perhaps we can improve both our lot and the lot of our patients. We need to convince them that our brand of Medicine, although expensive, is critical to the well being of our citizens. It is more valuable than the beaches of Normandy or the oil of Kuwait.

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by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

AMA to Coordinate Comments On HCFA E&M Documentation Guidelines

The Health Care Financing Administration (HCFA) announced that they will move forward with the development of replacement documentation guidelines for the 1995 and 1997 versions now in use. Despite strong objection from the AMA, HCFA has decided that some "counting" or numerical formulas are necessary to assure consistent interpretation of the guidelines by Medicare carriers. For this reason, they will be using the "new framework" which was developed earlier this year as a starting point.

The CPT Editorial Panel will provide technical editorial advice on HCFA's new guidelines, in an effort to ensure that the final product will minimize physicians' burdens, diminish counting formulas as much as possible, and are consistent with CPT definitions. Toward this end, the AMA is once again asking for physicians' comments on the "new framework". Physicians who are interested in providing input can download the guidelines from the AMA website at www.ama-assn.org/emupdate or contact Marilyn Rissmiller at CMS and request a copy. Many physicians responded to the call for comments on the "new framework" in July 1998. As the current draft has not changed substantially* CMS will forward these responses to the AMA again.

The AMA has asked that the state medical societies consolidate their member responses and forward them as a group by November 25, 1998. **In order to meet this deadline, comments should be received at CMS no later than Tuesday November 24, 1998.**

You can mail or fax your responses to:

Colorado Medical Society

Attn: Marilyn Rissmiller

PO Box 17550

Denver, CO 80217-0550

Fax # (303) 771-8657

Phone # (303) 779-5455 or 1-800-654-5653, ext. 2428.

**The only changes to the "new framework" were in the examination items listed under Eyes.*

CROP Makes Three Grants to Rural Projects!

The Colorado Medical Society Foundation (CMSF) approved the first three grants on behalf of the Colorado Rural Outreach Program (CROP). The communities that will benefit from these funds are Haxtun, Eads and the San Luis Valley.

Dr. Jose Hinojosa of Haxtun will receive assistance with medical education loan repayment. The Haxtun Hospital District will match the \$10,000 contribution from the CMSF. In Eads, Weisbrod Memorial County Hospital will receive \$2,400 toward the purchase of a much-needed cardiac telemetry unit, installation of the equipment and training on its use. The hospital will match the contribution dollar for dollar. Two scholarships each in the amount of \$2,400 will be awarded to lower income and minority students in the San Luis Valley. The scholarships will allow the students to participate in the San Luis Valley Area Health Education Center's *Grow Your Own - Summer Health Careers Institute*.

The CMSF Board of Directors and CROP Resource Development Committee members are thrilled to have been able to approve funding for these very important projects and thank the many contributors who have made the funds available for these granting opportunities. Look for a feature story on the funded projects and progress of CROP in your December issue of *Colorado Medicine*!

Seeking Declaratory Orders Before the BME

By David A. Burlage & Patrick T. O'Rourke
Montgomery Little & McGrew, P.C.

Under Colorado law, all state agencies must provide a process for entertaining declaratory orders, which are designed to remove uncertainties in how the law is understood and applied. The Colorado Board of

(Continued on next page.)



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Seeking Declaratory Orders Before the BME (continued)

Medical Examiners ("BME") is no exception and allows physicians to request declaratory orders in an effort "to terminate controversies or remove uncertainties with regard to the applicability of statutory provisions or rules or orders of the Medical Board . . ."

The declaratory order process is underused in the State of Colorado. Although physicians can seek the advice of counsel in determining whether a particular practice would violate the Medical Practices Act, the BME is not bound by any attorney's opinion. If, however, the BME issues a declaratory order to resolve a disputed issue of law, it will be bound by its determination. Consequently, physicians can rely upon the BME's declaratory order when planning future courses of action.

A physician seeking a declaratory order from the BME must file a petition setting forth the following: (1) the physician's name, address, and professional designation (i.e. -M.D., D.O., D.P.M); (2) the statute, rule or BME order to which the petition relates; (3) a concise statement of the facts necessary to demonstrate the nature of the controversy or uncertainty in the application of the law and the manner in which the statute, rule or BME order applies or potentially applies to the physician; and (4) a concise statement of the declaratory order that the physician seeks.

Two portions of the petition merit further discussion:

First, the statement of facts is particularly important because it must provide sufficient detail for the BME to understand the physician's petition. More importantly, if the physician presents an incomplete or inaccurate statement of facts, the declaratory order may not resolve the pending controversy. Any declaratory order applies only to facts that the BME ruled upon.

Second, the physician should think carefully about the what he or she wants the BME to state in its declaratory order. To the extent that the physician can craft a declaratory order that focuses on the precise issue raised in the statement of facts, it is more likely

that the BME will consider adopting it. The BME, like all administrative agencies, is hesitant to adopt declaratory orders that are overly broad and might bind its hands in controversies arising under a different set of facts.

Once the physician submits a petition for declaratory order, it lies within the BME's discretion whether to entertain it. The BME will normally not entertain a petition for a declaratory order under the following circumstances: (1) when ruling on the petition will not terminate the controversy or remove uncertainty in the application of the law; (2) when the physician has another adequate legal remedy that will accomplish the same goal as the petition; and, most commonly; (3) when the petition involves any question, subject, or issue that is currently the subject of a hearing, investigation, or complaint pending before the BME. The BME invariably declines to hear a petition from any physician who is currently under investigation for an alleged violation of the Medical Practices Act.

If the BME determines that it will rule on the physician's petition, the BME may issue a declaratory order without holding an evidentiary hearing. The physician may be asked to file a written clarification of factual matter, a written brief, or a memorandum setting forth his or her position. During any such non-evidentiary hearing, the BME may take administrative notice of commonly known facts contained within its expertise.

Although rarely utilized, the BME may also hold an evidentiary hearing to obtain additional facts or to determine the truth of the facts set forth in the petition. Any evidentiary hearing is conducted according to the procedures of the Administrative Procedure Act, which require the BME provide the physician with notice of the factual matters that it intends to explore, an opportunity to present witnesses, exhibits and arguments, the opportunity to cross-examine any witnesses presented by the BME, and the opportunity to be represented by counsel. During the evidentiary hearing, the physician bears the burden of proving: (1) the facts stated within the petition; and (2) all of the facts necessary to show the nature of the controversy or uncertainty in the applicability of the law; and (3) the manner in which the statute, rule or order in question applies or potential applies to the physician.

Once the BME issues a declaratory order, the physician, if he or she is dissatisfied with the results, may seek further judicial review. Judicial review of BME actions, including declaratory orders, normally takes place before the Colorado Court of Appeals.

In summary, by providing a mechanism for physicians to resolve controversies arising under the Medical Practice Act, the declaratory order process may be a valuable tool for establishing the boundaries of the physicians' relationship with the BME. A declaratory order to resolve an ambiguity in the Medical Practice Act helps physicians structure their medical practices in a manner that will allow them to avoid professional discipline.

Where the Coad Meets the Road

November 18th morning conference, "Where the Code Meets the Road" promises to be a ride of a different kind. The conference, sponsored by the Rocky Mountain Center for Healthcare Ethics, is aimed at all those who deliver and receive healthcare. The day will commence with a keynote address by Rick Wade of the American Hospital Association. Rick will share results from consumer focus groups held across the country in a presentation entitled "Consumer Reality Check."

Staff from the Rocky Mountain Center for Healthcare Ethics will present the new Colorado Code of Ethics for Healthcare, the culmination of a two-year project involving over 700 Coloradans in locations across the state. In a presentation entitled "Carpooling on the Healthcare Highway," panelists representing hospitals, physician groups, employers and managed care organizations will share with conference participants ways in which they have implemented or intend to implement the Code.

The second half of the morning will examine concerns and possible responses to consumer and patient dissatisfaction in a session entitled, "Responding to Road Rage". Ralph Pollock, AP Group, will set the tone with the status of the Patients' Bill of Rights. Karen Ignagni, President of the American Association of Health Plans, and Charles Inlander, President of the Peoples' Medical Society, will address consumer issues and ways those in healthcare are responding and ought to respond to consumer hostility and distrust.

Participants will have time to respond to presenters in a morning that promises to be lively.

When: November 18, 1998 7:30-11:45 a.m.

Where: Inverness Hotel and Golf Club
200 Inverness Drive West, Englewood

Fee: \$65 before November 11, 1998
\$80 after November 11, 1998

Registration includes a copy of the Colorado Code of Ethics for Healthcare, a \$20.00 value.

To register, send contact information with your payment to:

Rocky Mountain Center for Healthcare Ethics
225 E. 16th Avenue, Suite 1050
Denver, CO 80203-1614
Phone: 303.831.4880 Fax: 303.832.7496
Email: rmche@ix.njanetnetcom.com

Medicare+Choice

The Balanced Budget Act of 1997 promoted more choice for seniors and the disabled enrolled in Medicare with the creation of Medicare+Choice. The "choices" were to include not only Medicare HMOs and traditional Medicare-Medigap, but also Provider-sponsored organizations (PSOs), Private fee-for-service plans and Medical savings accounts (MSAs).

The key word is *were* - no one was ready to offer any of the new choices. At least for 1999, Medicare beneficiaries will only have the two familiar options. But the lack of choice did not keep Congress or the Health Care Financing Administration (HCFA) from going forward with the big educational "push". This fall Medicare beneficiaries will be receiving information from HCFA on the *future* choices, and will have the opportunity to attend informational sessions throughout the state. (This is probably in part to prepare them for the fact that Medicare is moving toward an annual fall open enrollment period.) HCFA's primary message this year is, **"If you are happy with the way you receive your Medicare benefits now, you don't have to do anything."**

But just in case, the following information may help you or your staff direct your Medicare patients to the appropriate place for assistance:

- Besides the traditional Medicare and supplemental plans, there are seven HMOs in Colorado. They are Antero, Cigna, HMO Colorado, Kaiser, PacificCare, Qual Med and Rocky Mountain HMO.
- HCFA has established a very good web page for consumers at www.medicare.gov. It has current information on the plans available in the area (by zip code), and compares the different choices. The consumer can even query for a comparison of a specific benefit or service.
- If they don't have access to the internet, in Colorado they can call the particular HMOs they are interested in and ask them to send a **Uniform Disclosure form** on their Medicare HMO products. When they receive the forms from each HMO, they should be able to compare the benefits side by side.
- To obtain information on the Medicare supplemental plans they can contact the Colorado Division of Insurance at 303-894-7499, ext. 356.
- If they have general questions they can contact the State Health Insurance Assistance program at 1-800-544-9181.

Physicians or their staff who have questions can contact Marilyn Rissmiller at CMS on 303-779-5455 or 1-800-654-5653, ext. 2428.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact information at the end of the listing.

2nd Annual Obstetrics Conference "Update in Obstetrics"

Friday, November 13, 1998
Colorado Springs, Colorado
Contact: Jan Hodge – Memorial Hospital (719) 365-5675

Heart and Stroke Satellite Symposium

Saturday, November 14, 1998
Four locations in Colorado
Contact: Laurel Petralia – American Heart Association
(303) 369-5433 ext. 228

Where the Code Meets the Road

Wednesday, November 18, 1998
Englewood, Colorado
Contact: Gerry Heeley, MA, STD – Rocky Mountain Center for Healthcare Ethics (303) 831-4880

2nd Annual Diabetes Conference "Think Like a Pancreas"

Friday, December 4, 1998
Antlers Doubletree Hotel
Colorado Springs, Colorado
Contact: Jan Hodge – Memorial Hospital (719) 365-5675

7th Annual Bugs and Drugs in the 90's

December 11 and 12, 1998
Contact: Gina Liscum – UCHSC
phone (303) 372-9050, fax (303) 372-9065, or e-mail
Regina.Liscum@UCHSC.edu

Fractures Below the Belt

January 14-16, 1998
Eldorado Motel
Santa Fe, New Mexico
Contact: CMS Office - Texas Tech University Health Sciences Center (915) 545-6685

30th Annual Cardiovascular Conference at Snowmass

January 18-22, 1999
Snowmass Conference Center
Aspen/Snowmass, Colorado
Contact: Registration Secretary, Extramural Programs – American College of Cardiology (800) 253-4636 ext. 695

5th Annual Pediatric Symposium "Growth & Challenges in Office Based Medicine"

Saturday, January 23, 1999
Sheraton Colorado Springs
Colorado Springs, Colorado
Contact: Jan Hodge – Memorial Hospital (719) 365-5675

Clinical Diabetes & Endocrinology

January 24-28, 1999
Snowmass Conference Center
Aspen/Snowmass, Colorado
Contact: Donna Loy (303) 789-9682 or (800) 421-3756

Ski & CME Midwinter Conference

February 21-26, 1999
Keystone Lodge & Resort
Keystone, Colorado
Contact: Patricia Ellis – Colorado Society of Osteopathic Medicine (303) 322-1752 or (800) 527-4578

25th Annual Vail OB/GYN Conference

February 21-26, 1999
Vail, Colorado
Contact: Linda Woodstock – UCHSC
phone (303) 372-9050 or fax (303) 372-9065

The 6th Annual Echocardiographic Workshop on 2-D & Doppler Echocardiography at Vail

February 22-25, 1999
Vail, Colorado
Contact: Registration Secretary, Extramural Programs – American College of Cardiology (800) 253-4636 ext. 695

CRASH 99: Colorado Review of Anesthesia & Ski Holiday

February 27 - March 5, 1999
Contact: Phyllis Tuller - UCHSC (303) 372-6301 or
<http://www.uchsc.edu/sm/anesth/crash.htm/>

Horizons in Surgery, presented by Department of Surgery CU School of Medicine

March 6-13, 1999
Breckenridge, Colorado
Contact: Sara Ellis (303) 315-5571

80th Annual Session American College of Physicians - American Society of Internal Medicine (ACP-ASIM)

April 22 - 25, 1999
New Orleans, Louisiana
Contact: ACP-ASIM Customer Service – American College of Cardiology (800) 523-1546

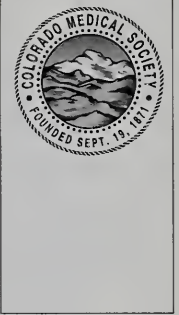
Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

Save the Date!

The Interim Meeting Educational Conference will be held on **Saturday, February 27, 1999**, at the Terrace Garden at Dove Valley.

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society

I've said it before! I'll say it again! Are you ready?

Doctor, are you ready for Y2K? What is there to do to be ready for the millennium? We've all been awash in the talk about the computers not being able to talk to one another and throwing our banking, investment and insurance records into a tizzy? Lately I've been imagining January 1st, 2000, and what it might look like at the Federal Reserve Bank, or the U. S. Treasury Department in Washington: the big, mainframe computer standing in the middle of the room, power off, tapes idles, discs stark still, but the last message still visible on the screen, says "THE END."

We might even see some computers suffering from a new dementia called computer amnesia; every time you boot one or turn on the power, it immediately asks, "Where am I?"

No joke, when I think how far we've all come in MY lifetime (which is obviously not very long), and then to have it end on January 1, 2000, all because we couldn't make the computers work past midnight, 12/31/99... WOW.

Granted, medical practice in one form or another is not going to end with any demise of the computer, but look around you! Ask yourself just what form medical practice is going to take in the new millennium? Will YOU be ready?

Colorado Medical Society is doing its best to help you to be ready. We've just completed two years preaching an awareness of likely new medical practice requirements, such as accountability,

patient relations, quality of service, new regulations such as E & M Coding, transferring of Medicare patients to managed care organizations or HMOs, "Medicare PLUS" and many more. We (CMS) can't make you be aware of these things; we can only supply you with the information from the best possible sources distributed by a highly qualified staff of doctor-friendly specialists.

So, you say, "What's the big deal? If it isn't clammed-up computers, what do we practitioners have to be prepared for? I thought you'd never ask.

First, the end of a century seems the perfect time for change. Beware of change. Not opposed to them, but wary of changes, such as legislative attempts to strip more authority from the Board of Medical Examiners, rules and regulations that strip doctors of still more medical and scientific authority.

We continue to work (very effectively, I might add) with the Colorado HMOs in keeping them abreast of physician concerns, as well as keeping our members aware of the HMOs' concerns.

CMS has made a major successful effort over the past few years to keep an effective and conscientious delegation from Colorado at the AMA table to actively participate in national medical practice policy.

We're closely monitoring national issues which will impact Colorado practice in the new century, and striving to make you aware of those issues.

Oh, I almost forgot: we are paying attention to the computer

"I've said it before! I'll say it again! Are you ready?"

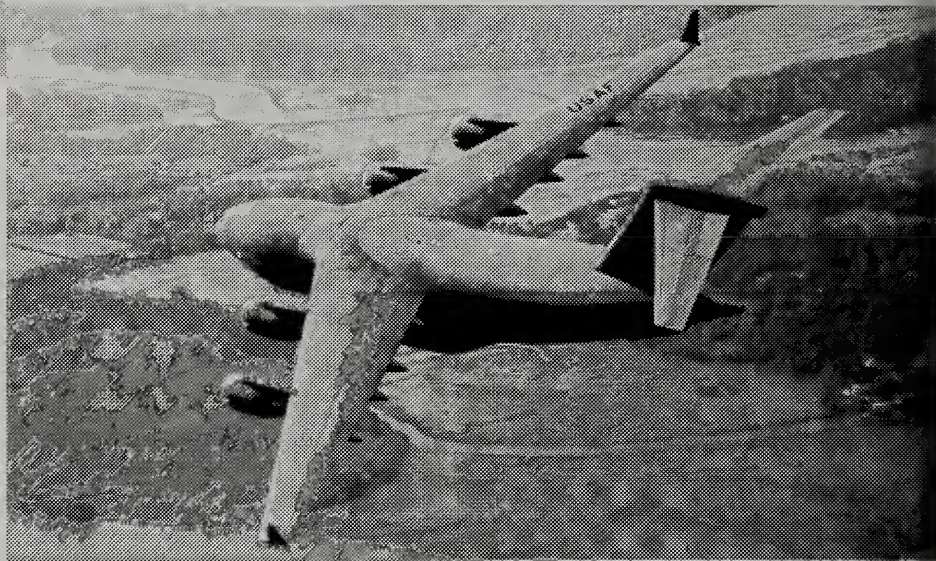
"snafu" which could occur in 2000. We don't need to fret too much what 2000 will bring. When CMS overhauled its information system (over 6 years ago before "Y2K" was ever mentioned publicly), our CMS Information Systems Manager bought a system which was built from the ground up, ready to deal with any millennium that happened along.

We're ready to help!



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Congratulations. . .



Dr. Lynn Parry, of Clear Creek Valley Medical Society presents Dr. Dean Sadler with an award recognizing his years of outstanding service to the House of Delegates. The award was presented to Dr. Sadler at the 1998 Annual Meeting in Steamboat Springs.

WHEREAS, the House of Medicine has been enriched by the loyal service of Dean Sadler, MD, and

WHEREAS, Dr. Sadler in his more than 50 years as a physician has served medicine in his community in many roles, including compassionate family doctor; hospital Chief of Staff; Clear Creek Valley Medical Society President, Senior Delegate and perennial member of the Board of Trustees; health plan medical director; and respected advisor and mentor, and

WHEREAS, Dr. Sadler has contributed to the success of the Colorado Medical Society through his active participation in many areas, including most recently as Chair of the Health Affairs Council and member of the Organizational Study Committee, and

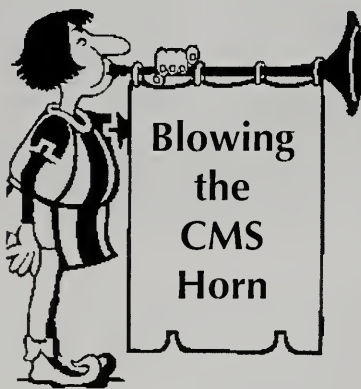
WHEREAS, after 32 years as a member of this Colorado Medical Society House of Delegates, Dr. Sadler will retire after this meeting from the Clear Creek Valley Medical Society Delegation, therefore be it

RESOLVED, that the Colorado Medical Society House of Delegates join the Clear Creek Valley Medical Society Delegation in paying tribute to Dean Sadler, MD for his many years of outstanding service to the profession of medicine and the patients he has served by passing this well deserved resolution.



Highlights of 1998 CMS Legislative Activities

*Christopher Unrein, DO
Chairman, CMS Council on Legislation*



1998 was a banner year for the number of legislative proposals (74) followed by CMS. It was also a successful year at the State Legislature and an overview of the high priority bills is provided herein for your information. CMS members may contact the Department of Government Relations for copies of any of the bills or the final version of the CMS Legislative Digest which lists all bills followed by the Society 1-800-654-5653, Ext. 2413 or (303)930-0413.

SB 036, Requirement for Licensure of Physicians Lawfully Practicing Medicine in another Jurisdiction (Wham): This bill, which adds language to the Colorado Medical Practice Act requiring

persons from out-of-state to hold a Colorado license if they practice telemedicine on more than an occasional basis, passed the Senate quite easily. Opponents to the measure "came out of the wood-work" when the measure reached the House and the bill was not passed until the final days of the legislature. You may contact our office for a summary of the final version of SB 036.

SB 041, Female Genital Mutilation (Rupert): CMS policy mandated support of this bill which would have deemed the procedure child abuse. An exemption for any medical procedure necessary for the preservation of a child's health was included. The bill passed the Senate but was killed in House Appropriations on a straight party line vote.

SB 075, Governmental Immunity for Certain Health Care Professionals Employed by Public Entities (Thiebaut): We were successful in defeating this measure proposed by the Colorado Trial Lawyers' Association which would have eliminated governmental immunity for physicians and dentists employed by public entities.

SB 099, Needle Exchange Program (Wham): CMS policy mandated support of this measure which would have enabled cities in Colorado to establish needle exchange programs. The bill passed the Senate but was killed in the House Health, Environment, Welfare and Institutions (HEWI) Committee.

SB 121, Concerning Partial-Birth Abortions (Congrove): CMS successfully opposed this measure which banned "partial-birth" abortions for the following reasons: (1) the legislative intrusion into medical decision-making; (2) the vagueness of the language to describe the procedure; (3) the lack of specific guidelines about gestational age; (4) the absence of exceptions for cases in which the banned procedure would be necessary to preserve a woman's health and (5) that the mother's life exception was too narrow. The Council on Legislation made their decision to oppose SB 121 after review of CMS policy contained in RES-53-P (AM'89) and analyzing the language contained in the bill.

HB 1019, Terms of Mandatory Health Care Coverage Provisions for Newborn Children and Requiring that Such Coverages Include a Minimum Length of a Hospital Stay After Childbirth (Morrison): CMS supported this proposal which requires mandatory coverage for newborn children and maternity under health care coverage policies – 48 hour hospital stay following a normal delivery and 96 hours following a cesarean section. The bill became law when the governor signed it on March 23, 1998.

HB 1046, Limited Prescriptive Authority for Chiropractors (Musgrave): We attribute the successful defeat of HB 1046 to the numerous physicians who took time to contact their legislators and urge

Highlights of 1998

(Continued)

opposition to this proposal which allowed chiropractors to prescribe and administer pharmaceutical agents. You can expect a similar bill to surface in 1999.

HB 1104, Required Automobile Insurance Coverage Amounts (Veiga): CMS lobbyists joined a host of colleagues to defeat HB 1104 which would have reduced the current mandatory minimum automobile insurance coverages from \$50,000 to \$5,000. The bill originated in the 1997 Interim Committee on Mandatory Automobile Insurance where committee members were struggling to address the high cost of automobile coverage in Colorado. The measure passed the House but was killed in the Senate Business Affairs Committee.

HB 1142, Use of Community Rating Criteria in Small Group Health Insurance Plans (Owen): HB 1142 would have allowed the premium rate adjustment factor used by small group sickness and accident insurers for health plans to be based on claims experience and health status. Passage of the bill would have dismantled the small group insurance reforms of recent years. HB 1142 was opposed by CMS and killed in the Senate Business Affairs Committee. It is expected that a similar proposal will be introduced during the 1999 session of the legislature.

HB 1205, Establishment of a Duty of Ordinary Care for Health Care Coverage Carriers (Kreutz): CMS had serious concerns regarding the original language in this bill but worked with the sponsor to amend the problem areas out of the measure. HB 1205 passed the House HEWI Committee but was killed in Appropriations.

HB 1216, Collaborative Drug Therapy Agreements Between Physicians and Pharmacists (Paschall): CMS strongly opposed this proposal which would have "allowed physicians and pharmacists

to enter into collaborative drug therapy agreements for the purpose of drug therapy management." Efforts of our members who took the time to contact legislators explaining the reasons for our opposition to this bill were responsible for defeating HB 1216 in the first committee.

HB 1225, Adjustment of the Fee for the Physicians' and Physician Assistants' Peer Health Assistance Program (Epps): This bill is a result of a resolution passed by the CMS House of Delegates and will in-

crease the fee assessed physicians and physician assistants to support the peer health assistance program from \$28 to \$50. The bill passed with minimal controversy.

HB 1384, Parental Notification of a Minor's Request for an Abortion (Hefley): The Council on Legislation relied on current CMS policy in taking a position of "Oppose" on this bill. The measure passed the House State Affairs Committee but was killed on 2nd reading in the House.

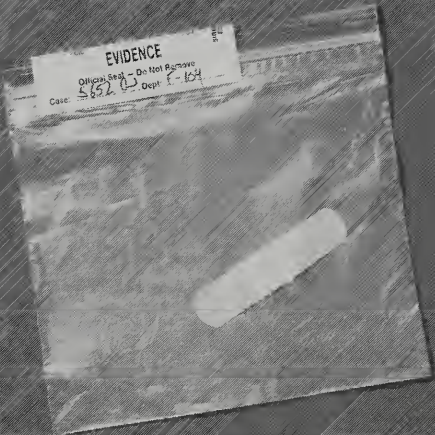


Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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Medical Exchange

Gary D. VanderArk, MD
Medical Editor



For the past year *Colorado Medicine* has had a strong monthly emphasis on accountability. This year we will alter that slightly and highlight one of the key tools of accountability - Informatics. The CMS's Medical Informatics Committee is sponsoring a series of education programs on Informatics and I think it is a most appropriate subject for *Colorado Medicine*.

In September I was delighted to receive a letter to the editor from Dr. Fries who strongly objected to one of my President's Letters. I was extremely pleased to discover that finally someone had read one. I think *Colorado Medicine* is a place for discussion and dialog so please let us know about your issues. Tell us if you agree or disagree with Dr. George Shanks, Sandi Maloney or me. After all, *Colorado Medicine* is about communication.

That reminds me of an attempt at humor that I picked up on the internet:

Subject: Why did the chicken cross the road?

Machiavelli: The point is that the chicken crossed the road. Who cares why? The ends of crossing the road justify whatever motive there was.

Freud: The fact that you thought the chicken crossed the road reveals your underlying sexual insecurity.

Darwin: Chicken, over a great period of time, have been naturally selected in such a way that they are now genetically dispositioned to cross roads.

Nixon: The chicken did not cross

the road. I repeat the chicken did not cross the road.

Clinton: Did you say chicks? Where are the chicks?

Jerry Seinfeld: Why does anyone cross a road? I mean, why doesn't anyone ever think to ask, "What the heck was the chicken doing walking around all over the place anyway?"

Louis Farrakhan: The road, you will see, represents the black man. The chicken crossed the "black man" in order to trample him and keep him down.

Martin Luther King, Jr.: I envision a world when all chickens will be free to cross roads without having their motives called into question.

Grandpa: In my day, we didn't ask why the chicken crossed the road, and it was good enough for us.

Bill Gates: I have just released the new Chicken 2000, which will both cross roads and balance your check book, although when it divides 3 by 2 it gets 1.499999999.

George Orwell: Because the government had fooled him into thinking that he was crossing the road of his free will, when he was really only serving their interests.

Colonel Sanders: You mean I missed one?

Karl Marx: It was historical inevitability.

Albert Einstein: Whether the chicken crossed the road or the road crossed the chicken depends on your frame of reference.

Ernest Hemingway: To die. In the rain.

So remember, this year let's communicate.

When Jim Leyland was introduced as the new manager of the Colorado Rockies he announced, "I'm not a miracle worker". As the new medical editor of *Colorado Medicine* I could say the same thing. The good news, however, is that unlike the Rockies, *Colorado Medicine* does not need a miracle. *Colorado Medicine* has been doing a great job of communicating with Colorado's physicians under the sterling leadership of our editor, Bill Pierson.

However, I do feel that having physician input in our magazine has a potential for making things even better. As a result I have once again volunteered for another job that I do not need.

C	o	r	a	d	o	P	h	y	s	i	c	i	a	n	N	e	t	w	o	r	k	,	I	n	c	.
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David C. Martz, MD
President, CPN

As of this writing, the New York Yankees are once again among the top two teams in major league baseball, adding to their record number of appearances in the World Series. Consistency of quality spanning many years has made them the team to beat. In the arena of managed care, Rocky Mountain HMO (RMHMO) has likewise emerged again in the top two Colorado HMO's in both local and national surveys.

The 1998 satisfaction survey published by the Colorado Business Group on Health shows RMHMO getting "higher than most Colorado health plans" in 5 of the 7 categories—more than any other HMO in the state. These included:

- (1) Getting a referral to a specialist;
- (2) Receiving care you and your doctor believed was necessary;
- (3) Ease of choosing a personal physician;
- (4) Overall quality of care and services; and,
- (5) Availability of information about eligibility, covered services, or administrative issues.

In a separate national ranking that included 7 Colorado HMO's and one Point of Service Plan published by U S News and World Report, RMHMO was one of only two Colorado HMO's receiving a 3-star

rating. No 4 star level was given in Colorado and score differences of less than 2.5 were not meaningful. With best in the nation getting 100 points, and worst given 0, RMHMO received an overall score of 75, one point below Kaiser's 76. The rankings were based on 28 quality measures from HEDIS data submitted to the NCQA's "Quality Compass". Yes, RMHMO is once again in the top levels of both member satisfaction and quality evaluation.

Colorado Physicians Network (CPN) takes pride in collaboration with an organization of such proven values. These attributes are essential to our marketing of Rocky Mountain Physicians Choice throughout the Front Range. Employers are taking notice, and requests for "quotes" are growing weekly. The recent letter of intent to include Millennial in CPN's Front Range network further enhances our affirmation of superior product as well as the ability to disseminate it.

We fully recognize that Rocky Mountain Physicians Choice is more akin to an expansion club than the New York Yankees at this juncture, but with consistency and values like ours, why not identify with the team to reckon with? After all, the Yankee tradition didn't just happen: it was created and grown from among the rest with a commitment to excellence—a vision we share!

Colorado Medical Political Action Committee

P.O. Box 17550 • Denver, Colorado 80217-0550 • 303-779-5455

You're too busy practicing medicine to play politics.

Every day you see the effects of health care reform on your practice. Every day you promise yourself that you will become more involved and help shape the future of medicine. But the truth is that sometimes you are too busy.

Fortunately you have COMPAC. Legislators are becoming aware of and educated by organized medicine. However, the Campaign Reform Amendment and legislator turnover in both Houses in 1998 may dramatically affect the legislative advances made for you and your patients.

Join COMPAC today and become personally involved in the future of health care in Colorado. Then rest assured the voice of organized medicine will continue to be heard at the state legislature. For information call (303) 779-5455, extension 2410 or 1 (800) 654-5653.



Bed Rest and Fluids Won't Cure This "Bug"

With a little more than a year to go to January 1, 2000, time is getting short for organizations to address the impact of the Year 2000 (Y2K) problem on their business. This article is intended to give you an overview of the efforts we're undertaking at Copic Companies to safeguard our viability and continued operations once the clock has struck midnight.

Y2K As a Risk Management Problem

At its heart, Y2K is a risk management problem that can be approached like any other:

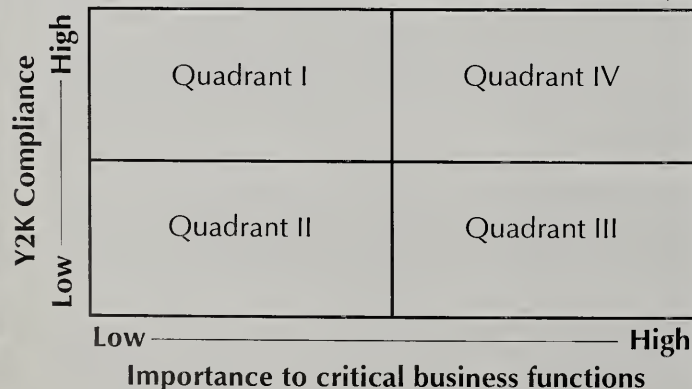
1. Identify and analyze risk exposures
2. Examine available risk management techniques
3. Select the most appropriate techniques and construct a program
4. Implement the program
5. Monitor the program

As of November 1, 1998, Copic Companies has completed steps 1, 2, and 3 shown above and is currently working on steps 4 and 5 -- implementing and monitoring the program.

Step 1: Identify and Analyze Risk Exposures

Copic Companies has assembled a management-level team charged with assessing the probable and potential impacts of Y2K on the critical business functions performed by Copic Insurance Company, Copic Financial Service Group, Ltd., Gadrian Corporation, and Practice Quality.

As is true in many other companies, our assessment revealed that Copic Companies' Y2K compliance varies across hardware and software for both our critical and non-critical business functions. We were able to classify



each of our Y2K systems exposures into one of the four quadrants shown above.

This structure classified for us graphically what we knew intuitively. Our resources -- people, time, and money -- are best spent addressing items and systems that fall in Quadrant III where importance is high and compliance is low. Problems presented by items or systems in Quadrants I and IV can be addressed on an ad hoc basis as they arise. And for those in Quadrant II, we can implement relatively inexpensive upgrades or design manual "work-arounds" that will suffice until resources allow us to -- or their importance requires us to -- reevaluate.

Steps 2 and 3: Examine Available Risk Management Techniques; Select and Construct a Program

Copic Companies' Y2K strategy includes a blend of risk management techniques such as avoidance, loss prevention, and loss control...techniques predicated on our active involvement in risk reduction.

- **Avoidance:** Challenges presented by items and systems in Quadrant III will likely require outright replacement with new hardware and software so as to avoid the risk of Y2K problems completely where critical business functions are concerned.
- **Loss prevention:** Where available at an acceptable cost/benefit ratio, hardware and software upgrades will serve as a loss prevention measure for items in Quadrant II; otherwise, items in this category may be "back-burnered" until something occurs to move them into another category.
- **Loss control:** This risk management technique is designed to minimize the impact of losses that cannot be prevented. In terms of Copic Companies' Y2K strategy, loss control means that we will rely on testing and documentation of the systems in Quadrant IV to assure ourselves of their actual compliance. Otherwise, we will address Y2K-related problems within these systems if and when they arise.

Steps 4 and 5: Implement and Monitor the Program

Copic Companies is in the process of implementing the Y2K program described above, with the goal of safeguarding our viability and continued ability to operate past midnight on December 31, 1999. The management-level Y2K committee continues to meet monthly to review progress and adjust the program as necessary. In order to ensure complete resolution, Copic Companies anticipates maintaining this committee and its schedule at least through June 30, 2000.

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Attention-Colorado Medical Society Members:

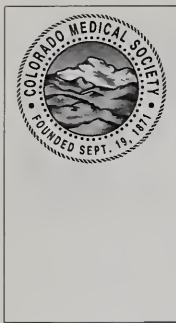
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John L. Lightburn, MD
Historian, Colorado Medical Society

Home Front, 1941-1946

Whiskey was really scarce. Scotch was all but impossible to find.

The striking feature of our nation during World War II was the complete domination of every aspect of civilian life by the "war effort". Looking back from our current position of affluence and resistance of government control, it is difficult to believe how willingly we all sacrificed and accepted the dictates of an enormously powerful central government in Washington, D.C. An example of how willingly we volunteered our support of our country is the following letter from the Colorado Medical Society to the Governor on the day after Pearl Harbor was bombed. Here is the letter:

Dear Governor Carr,

The official bodies of the Colorado State Medical Society are fully aware of the war which has arisen in the last 24 hours. Through appropriate boards and committees, the society has for many months undertaken to prepare itself and its

members to meet such a contingency. This program has been coordinated with the programs of all other state medical societies as a national endeavor of the American Medical Association. Please accept this letter as our offer of the complete services of the Colorado State Medical Society and its membership to be used in any manner which you and other constituted civic or military authorities of our state see fit.

Sincerely,

Guy C. Carey, MD

Grand Junction, President

John C. Bouslog, MD - Denver,

Chair of the Board of Trustees

Harvey T. Sethman - Denver,

Executive Secretary

Think of it. Officials of the medical society telling a government official to use the society and its members in any way he sees fit! But that is how most of us felt; we were ready to serve our country. Governor Ralph Carr replied with a grateful letter saying members of the society were "the most unselfish group in our citizenry" and "your patriotism and efforts will be recognized and rewarded through the years to come."

Patriotic fervor touched all of us. Every activity in the country had only one purpose: win the war. Every industrial and manufacturing facility in the country was converted into a factory for arms, munitions, tanks, airplanes and various machines of war. The manufacture and sale of automobiles, radios, appliances, furniture and other items was discontinued or drastically reduced; no new homes were built so a hous-

ing shortage developed. There was rationing and price control. Most car owners were allowed to have four gallons of gasoline each week, sometimes less. They had a green "A" sticker on their windshield. Doctors and other essential persons were given a "C" sticker and were allowed to purchase more gasoline to do their hospital rounds and respond to emergencies. No new cars were available, so they had to keep their old cars going. There were shortages of meat, sugar, cigarettes and candy. Cigarettes were needed by the soldiers. Whiskey was really scarce. Scotch was all but impossible to find. Some medical students would give the liquor store clerk a "tip" if he could find a bottle of bourbon. Women's skirts became shorter, but silk stockings disappeared from the market. Nor were there Nylon stockings, because the army needed the nylon for parachutes.

In spite of the shortages and rationing, everybody had enough to eat. In some respects, we may have been healthier than we are now. Fewer of us were overweight. People were supportive of each other. There was less crime. If anybody complained, they were pointedly asked, "Don't you know there is a war going on?"

Surprisingly, people took the restrictions and shortages very well. Truth be told, they were scared and worried as the newspapers continued printing stories about the German's control of Europe and their offensive in the outskirts of Leningrad and Moscow, and their successful march across Africa. The Japanese had invaded China, Indo-



Home Front, 1941-1946

(Continued)

Colorado law dictates that the State Patrol furnish transportation and a driver for the governor. When Ralph L. Carr was chief executive (1938-1946), war requirements meant new cars were scarce. Thus, Governor Carr and his State Patrol driver (identity here undetermined) tried out the latest in tandem bicycles. Even though the governor "promised to do his share of pedaling," the bike was dismissed as a pretty silly idea, and the governor instead traveled about the state in a State Patrol car of the day.

nesia, the Philippines, Malaysia and Indochina. At Pearl Harbor, they had destroyed a significant part of our Pacific fleet. They were led by charismatic leaders bent on world domination. Yes, we were scared, real scared. But in spite of the gloomy news, we were upbeat people. We danced to the music of Glen Miller, Tommy Dorsey and other "big bands." We loved to hear Bing Crosby sing "White Christmas" and we laughed at Spike Jones and the "City Slickers" as they played and sang "Heil-Sptzz, Right in der Fuhrer's Face".

Reading through the journals and media of those years presents a picture of the patriotic fervor shown by the physicians during those early months of the war. The editorial pages of the Rocky Mountain Medical Journal encouraged the membership to do their share. An example of the rhetoric is found in the address by Dr. T. Leon Howard to the American Urological Association in Colorado Springs. Referring to the 4th Chapter of Genesis where Cain asks God "Am I my brother's keeper?", Dr. Howard said, "... I would ask you; 'Are we our brother's keeper?' Are we as members of the greatest of

all professions going to evade this question and continue along the lines of least resistance, thinking only of individualism? We have the power to shape the destiny of nations. We are the only profession under the shining sun that can say dictators, kings and presidents, 'Stop! You have gone far enough...' Monuments have been built from one end of the world to the other to the human destroyers of life, for theirs was the glory gained amid the blare of trumpets and the thunder bursting shells at the front, and not in the stifling, blood soaked operating rooms over the mangled forms that the hero rode to fame while mutilating." After several more paragraphs, he concluded with, "To a man we will back our country in this fight, for it is probably going to be the last fight for freedom, but when it is over, let us stay united sufficiently long to demand a place in the national cabinet and see that the representative is one who will not sell our birthright for a mess of pottage or our liberties for thirty pieces of silver." The assembled urologists responded with a standing ovation. It was a real stem-winder! Although not as eloquent as Dr. Howard, the

editorial writers and authors continued with strong support of the war effort.

Responding to the appeal to their patriotism, over 30% of the practicing physicians in the state eventually volunteered. And hundreds of nurses also volunteered, leaving the civilian hospitals short of essential personnel. Both doctors and nurses had to work very long and difficult hours.

A look at how the officers of the medical society responded to the war is illustrative of how the "home front" coped with the war. Here is a brief glimpse of the four presidents who presided over the Colorado State Medical Society during the war.

Guy C. Cary, 1941-42. Dr. Cary, 71st CMS president, was an ophthalmologist from Grand Junction. He had been in the service in World War I. He was a deeply religious man who had no tolerance for unethical practice. On the Sunday the Pearl Harbor was



Home Front, 1941-1946

(Continued)

bombed, he made a long distance call to Harvey Sethman and asked him to send the letter to Governor Ralph Carr that is quoted earlier in this article. This highly moral and religious man was determined that the medical community should do its part. After his presidency, he was known for years as the toughest member of the grievance committee of the CMS.

Ralph S. Johnston was elected president-elect before the war had started. Little did he know how busy he was going to be. He was the chief surgeon for the A.T. & S.F. Railroad Hospital, one of the busiest railroads in the nation. Four of the ten doctors in Lajunta had volunteered for military service including his son, Ralph Johnston, Jr. So he participated very little in the affairs of the society. He declared himself too busy to attend meetings of the board of Trustees, returned letters unanswered and asked the vice-president to make all presidential committee selections and to perform other presidential duties. He spent most of the daylight hours at the hospital, but never turned down the request for a house call. Spending as many as 70 hours a week in his practice, he still had time to support the local Boy Scout troop which became famous as the "Koshare Indians."

The 73rd President was George P. Lingenfelter, 1943-44. He was a much loved Denver Dermatologist. He was the son of a Confederate soldier who had graduated from the Missouri Military Academy and at heart was very much a soldier. Oh yes, he was also a real "southern gentleman". He was a sol-



dier in the Spanish American War and volunteered again in 1917 in the US Navy where he eventually was given the rank of Lt. Commander. He enjoyed periods of active duty until 1930. He tried every stratagem to get active duty in World War II (at age 69) and shed real tears at the Navy's repeated "No." So he devoted his enormous energies to guiding the CMS through a difficult war year. The CMS staff was limited by



Harvey T. Sethman
Exec. Dir.-CMS

the absence of Harvey Sethman who had become an officer in the Medical Administrative Corps. Toward the end of his term as president, he suffered a myocardial infarction. Two weeks after admission to the hospital, he left the hospital against his doctors advice to deliver his closing presidential report in 1944. For twenty years, he was director of Denver's Steele Isolation Hospital. Back in 1922, he had lead the city wide effort to vaccinate the total population during the 1922 "black" small pox epidemic. He finally retired at age 90. Nearing 94, he was donning his tuxedo for a Country Club dinner when he laid back on his bed and died of cardiac arrest.

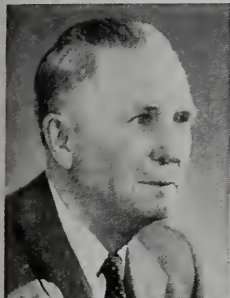
Edward R. Mugrage, 1944-45 was our last war time president. All University of Colorado Medical Graduates know Dr. Mugrage as "Uncle Ed". He was a brilliant pathologist and teacher, a chemist, an expert in public health matters, a trusted consultant and above all a decent, gentle, compassionate man. He was born in Leadville, the son of a pioneer doctor. As a child he suffered mastoid infection which left him with a 90% hearing loss. At age 25, he suffered a severe attack of viral encephalitis leaving him with an intention tremor of his extremities



and his voice. In spite of these significant disabilities, he completed his medical education, became an outstanding teacher and guided the CMS through the last year of the war. His goal for the society was to plan for the returning medical officers, to help the physician veterans reestablish their civilian practice. Over 100 had returned by the spring of 1946.

Midway through the war, the love affair (or rapprochement) between organized medicine and the Federal government began to unravel. In his inaugural speech in 1943 Dr. Lingenfelter started his remarks with usual expression of gratitude and then said "...may I be pardoned for presenting at once what seems to me to be the most imminent danger to the freedom and action of American Medicine. No informed and thoughtful person can fail to recognize the threat to medical progress and the public health in some of the proposed legislation in Washington." He went on to present a very strong case against the provisions of the Wagner-Murray-Dingell Bill. The honeymoon was over! The liberals in Washington had big plans for the post war period and the CMS would have none of it. Where the *Rocky Mountain Medical Journal* had many articles and editorials exhorting its readers to support the country in its war effort, now the pages had numerous articles on the dangers of "socialized medicine". The Wagner Bill, which provoked the uproar, was a proposal for a United National Insurance Plan. It was an extremely idealistic and ambitious plan which expanded the Social Security System to include, in addition to an old age retirement plan, disability insurance, workmen's compensation and compulsory health insurance paid for by a 12% contribution (tax) from each workers salary (6% from the worker and 6% from the employer). The AMA and the CMS vigorously opposed passage of the bill. Perhaps most eloquent was Bradford Murphey, MD secretary of the CMS who chided the AMA and the CMS for their ineffective opposition to the proponents of the Wagner-Murray-Dingell Bill.

Here is how he started his talk at the Regional AMA conference in June, 1946; "American Medicine, as we have known it in our lifetime, is in deadly peril. It is threatened by



many grave dangers inside and outside the profession. It is threatened from within by selfishness and greed on the part of some and by apathy and indifference

on the part of many. It is threatened also by faulty professional organization, by poor medical society discipline, and by timid leadership, both locally and nationally." Brad was a strong believer in solo private practice, and he was responding not only to the dangers of "socialized medicine" but also to the changes that the war had brought to our society and the practice of medicine.

Next month, we will look at some of the important medical events in Denver and Colorado during World War II.

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
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The self-study module prepares health care providers to:

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Mountain-Plains Regional
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*This project is funded by the Health Resources and Services Administration,
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Colorado Medicaid Program

1998 Fiscal Agent Transition

December 1, 1998

The following are excerpts from the Medicaid Transition Guide that was mailed to all Colorado Medicaid Physicians.

The transition will require that physicians change some of the procedures used to manage Medicaid clients and to submit fee-for-service Medicaid claims.

Background

In late 1995, the Colorado Department of Health Care Policy and Financing issued a request for proposals for a replacement Medicaid Management Information System (MMIS) and fiscal agent services. The twenty-year-old claims processing system could not effectively meet changing program requirements or provide efficient access to Medicaid information and the fiscal agent contract was due for competitive re-bid under State and Federal rules.

The State selected Consultec, Inc. to install the replacement claims processing system (MMIS) and to provide fiscal agent services. After the contract award, Consultec, a Georgia-based company with Medicaid fiscal agent contracts in several states, established offices in downtown Denver and began the complex process of designing and installing the new Colorado MMIS.

Transition Date— December 1, 1998

Electronic batch claims testing

Anyone who transmits electronic batch claims must test electronic transmission and report retrieval capability before the transition. Consultec is conducting testing now.

- Physicians and agents should complete testing as soon as possible. Waiting to test until late in the transition period risks being unable to submit claims on the transition date. Specifications are available from the Colorado Medicaid fiscal agent Internet web page at www.consultec-gcro.com.

Billing agent registration

Billing agents—anyone who transmits electronic claims and is not an enrolled Medicaid Physician—must register with the new fiscal agent, Consultec, and obtain a registration number. Consultec is conducting billing agent registration now.

- Physicians should contact their vendors and billing agents and **INSIST** that they complete the registration process now. In most instances, agents must register before testing can begin.
- Agents may obtain the agent registration form from the *Agreements* icon on the Colorado Medicaid fiscal agent Internet web page at www.consultec-gcro.com.

Impact on physicians

The transition will require that physicians change some of the procedures used to manage Medicaid clients and to submit fee-for-service Medicaid claims. Policies and procedures for interacting with Medicaid managed care programs are not changed. Physicians should expect the types of changes noted below.

Changes caused by the transition

Physicians will have to change procedures as they respond to specific dates when activities are discontinued by the old fiscal agent, Blue Cross Blue Shield of Colorado (BCBSC), and begun by the new fiscal agent, Consultec.

Paper claims cut-off date — **November 6, 1998**. This is the last date Blue Cross Blue Shield receives paper claims, adjustment requests, and correspondence.

- Paper claims, adjustment requests, and correspondence received by BCBSC after 3:00 pm on November 6th will be forwarded to Consultec for processing.
- Continue to file as many electronic claims as possible.
- Adjustments will be processed in the following manner:
 1. Until October 16th BCBSC will receive and process adjustment requests. The adjustments will appear on remittance statements produced by BCBSC.
 2. Between October 17th and November 6th, BCBSC will receive and review submitted adjustment requests and refer them to Consultec. The adjustments will appear on the remittance statement after the December 1st transition.
 3. After 3:00 pm on November 6th, adjustments will be referred to Consultec for review and processing.
- Paper claims and adjustments processed by Consultec will appear on remittance statements after transition.
- BCBSC will reply to correspondence received by 3:00 pm on November 6th.
- Continue filing claims throughout the transition period. To allow for US Postal Service delivery, physicians should begin addressing paper claims, adjustments and correspondence to Consultec approximately 3 days before the cut-off date. Following are the addresses for Consultec:

Paper Claims

P O Box 30

Denver Co 80201-0030

Correspondence

P O Box 90

Denver Co 80201-0090

- For timely filing purposes, both fiscal agents will record the receipt date of all documents. Holding paper claims for submission after the transition may create timely filing problems and cause processing delays
- All claims processed by Consultec must incorporate the claim data changes described in the Transition Guide even if the claim dates

of service are before the December 1st transition date.

- Physicians who submit claims on the Colorado 1500 claim form should use the HCFA Place of Service (POS) codes identified in the Transition Guide for each specific claim or service type.

BCBSC Prior Authorization cut-off dates:

Durable Medical Equipment and Supply – **November 6, 1998**

Home and Community Based

Services – **November 13, 1998**

Home Health – **November 17, 1998**

Dental – **November 17, 1998**

Prescription drugs – **November 23, 1998**

- Prior Authorization Requests (PARs) received at BCBSC after 3:00 pm on the cut-off dates will be forwarded to Consultec for processing. In urgent situations and for wheelchair repairs, BCBSC will work with providers and coordinate PAR approvals with Consultec to support prior authorization processing throughout the transition.
- To allow for US Postal Service delivery, providers should begin addressing PARs to Consultec approximately 3 days before the cut-off dates.
- **Continue submitting PARs to other agents** – including CFMC and the Division of Developmental Disabilities. These agents will process the PARs and submit the information to the correct fiscal agent.
- Please do not hold PARs for submission after the transition. Maintaining regular PAR submissions allows Consultec to conduct preliminary review before the transition date. Holding PARs for submission after the transition will create processing delays.
- Consultec will begin entering PAR information into the claims processing system and mailing PAR letters on the transition date. Providers may inquire electronically about the status of PARs using WINASAP software.
- For **Prescription drug prior authorizations**, prescribing providers must call PDCS at 1-

800-365-4944 on and after the prescription drug prior authorization start-up date.

Consultec prescription drug Prior Authorization start-up date – November 25, 1998 at 8:00 am

- Prescription drug prior authorization is available by telephone Monday through Friday, 8:00 am to 5:00 pm
- The prescribing physician must telephone prior authorization requests to PDCS at 1-800-365-4944.
- Drug prior authorizations are not pharmacy specific (except for lock-in clients) and are not NDC specific.

Automated Medical Payments

(AMP) system (electronic) claims cut-off date – **November 20, 1998 at 10:00 pm** (except prescription drug claims).

- Claims must be submitted and accepted by 10:00 pm
- BCBSC will continue processing prescription drug claims until the drug claim cut-off date.
- Claims that are not accepted by 10:00 pm must be held for submission to Consultec after the transition date.

REMINDER: Always verify eligibility before providing services. Eligibility verification will be available without interruption throughout the transition.

AMP (electronic) claims submission start-up – **December 1, 1998 at 12:00 noon**

- All claims processed through the new MMIS, including rebills, must incorporate the claim data changes described in the Transition Guide regardless of service dates.
- Physicians should install and use WINASAP to verify eligibility. Providers who must continue using NECS Interactive Software for eligibility verifications must install and use the updated NECS version.

(Continued on next page.)

Colorado Medicaid Program

(Continued)

AMP eligibility verification cut-over – November 30, 1998

- From 6:00 am until 10:00 pm on the cut-over date, physicians will be able to verify eligibility in both systems – the old system and the new.
- The 16-hour overlap period allows physicians to process an eligibility verification transaction in the new system before the transition date. The overlap period provides an opportunity for providers to test the new AMP interactive software while maintaining access to eligibility information through the old system.
- Consultec begins processing electronic eligibility verification transactions at 6:00 am

Colorado Medicaid Eligibility Response System (CMERS) – Automated voice response system – Denver Metro (303) 534-3500, Colorado Toll Free 1-800-237-0044.

Fax-Back eligibility verification – 1-800-493-0920

- To use Fax-Back eligibility verification, the physician's fax number must be recorded in the provider files. Requests to add the fax number to enrollment records must be made in writing. Completing the physician update form in the Transition Guide is an easy way to send the fax number to Consultec.
- Physicians should install and use WINASAP to verify eligibility. Physicians who will continue using NECS Software for eligibility verifications must install and use the updated NECS version.
 - At 10:00 pm, BCBSC discontinues eligibility verification processing.

Last pre-transition payment processing cycle – November 25, 1998

- All claims will be paid or denied.
- No claims will remain in suspense.
- No claims will be transferred to Consultec.
- Denied claims must be rebilled to Consultec.

- Electronic funds transfer (EFT) payments will be processed as usual.
- BCBSC will mail paper remittance statements that are not retrieved by 10:00 pm on November 30th.
- Physicians will be able to retrieve remittance statements for the BCBSC bulletin board until 10:00 pm on November 30th. Remittance statements that are not retrieved by 10:00 pm on November 30th will not be available electronically after the transition.

Payment processing start-up – December 4, 1998 at 6:00 pm

- Electronic claims that have been accepted for processing by 6:00 pm on Friday, December 4th will be included in the payment processing cycle.
- Recognizing that the 6:00 pm deadline is earlier than the pre-transition deadline of 10:00 pm, Consultec will evaluate the continuing need for the earlier deadline. If possible, the deadline will be extended. Physicians will be notified by bulletin, by remittance statement message, and on the Internet when processing cycle times are changed.
- Electronic funds transfers will be processed as usual. Payments from the first Consultec payment processing cycle will be transferred on December 11th.
- Consultec will mail paper remittance statements and warrants (checks) as has been done in the past.
- Electronic remittance statements will be available on MEVSNET by noon on the following Monday.
- Physicians must arrange for electronic report retrieval through Electronic Data Interchange (EDI) Support at 1-800-987-6721. At the time of sign-up, providers receive instructions to guide them through the report retrieval process.

Consultec fiscal agent start-up – December 1, 1998 at 8:00 am

- Consultec's Provider Services call center begins operation at 8:00 am
- Consultec begins MMIS entry and

processing of paper claims, correspondence, adjustment requests, and PARs.

Fiscal Agent procedural changes

As Consultec begins operations, providers will use different telephone numbers and different addresses. Procedures performed one way by BCBSC may, after transition, be done differently.

Changes associated with a new claims processing system

Physicians will see some differences in the information displayed on reports created by the new system. There will also be new procedures associated with electronic data interchange through the AMP system.

Things that don't Change

The Colorado Department of Health Care Policy and Financing determines Medicaid policy. Consultec, in its role as the Colorado Medicaid fiscal agent, does not set or change policies for the Colorado Medicaid Program. Policies and procedures that are not described as a change in the Transition Guide remain as they were before the transition. For example, timely filing is unchanged by the transition.

The Transition Guide contains detailed information to help physicians navigate through the Transition.

Transition Communications

The communication avenues described below are available to physicians throughout the transition.

Current Medicaid operations

Until the transition date, providers must continue to call Medicaid Communications at BCBSC with claims processing and current fiscal agent operational questions. Physicians should continue to direct prior authorization questions to the authorizing agent or to Medicaid Communications.

AMP transition questions

Consultec's EDI Support Unit will answer technical questions about AMP claim submissions, batch

submission testing, and report retrieval. EDI Support is available Monday through Friday from 6:00 am to 5:00 pm. Physicians and vendors may contact EDI Support now with questions about testing and report retrieval.

• **Contact EDI Support at 1-800-987-6721**

Batch claim submission testing

Vendors and physicians who submit batch AMP claims must test telecommunication, claim submission, and report retrieval capability before submitting claims to the new MMIS. EDI Support conducts the testing

Electronic report retrieval

After transition, batch response reports and remittance statements will be posted to MEVSNET, Consultec's reports retrieval Intranet. An Intranet is a secured environment used to post documents containing confidential information. Using MEVSNET is like using the Internet. A web browser is required to retrieve Intranet reports but an Internet Service Provider (ISP) is not necessary. If physicians do not have Intranet access capability (don't have Windows, etc.), arrangements can be made to retrieve reports from a bulletin board system.

EDI Support arranges for electronic report retrieval. Physicians who use AMP interactive software and wish to retrieve remittance statements electronically should call EDI support.

AMP software installation

All physicians will install new AMP interactive software: Either the new WINASAP software or the final version of the DOS-based NECS software. Two to three weeks before the transition date, Consultec will mail WINASAP software to AMP software users. BCBSC will distribute the final transition version of the DOS-based AMP software. Physicians should call EDI Support if they have difficulty installing either software.

• **Contact EDI Support at 1-800-987-6721**

Colorado Medicaid on the Internet

Consultec's Colorado Medicaid Internet web page contains transition information. As publications and manuals are distributed, the documents will be placed on the web page. Throughout the transition, Consultec will update the web page to answer common questions from the transition workshops. Physicians should look at the web page frequently – at least weekly – throughout the transition. The Address is: www.consultec-gcro.com.

Consultec Provider Services

Consultec's Provider Services Call Center begins operations – taking provider calls – on the transition date. Until regular operations begin, Consultec has established a telephone message center where providers may leave a message. Periodically, Consultec staff will retrieve messages and contact the provider by telephone.

• **The Consultec Transition Message Center telephone number is (303) 820-2196.**

Fiscal Agent Telephone Numbers

Medicaid Provider Services

Available Dec. 1, 1998, at 8:00 am
Monday –Friday 8:00 am - 5:00 pm
Denver Metro (303) 534-0146
Colorado Toll Free 1-800-237-0757
Fax (303) 534-0439

Prescription Drug Card System

Prior Authorization Help Desk

Monday –Friday 8:00 am - 5:00 pm

Pharmacy Help Desk

Monday –Friday 6:00 am - 10:00 pm,
Saturday 6:00 am - 8:00 pm,
Sunday 8:00 am to 7:00 pm
Toll Free 1-800-365-4944
Fax 1-877-614-1078

- Available for prior authorizations November 25, 1998, at 8:00 am
- Available for drug claim submissions Dec. 1, 1998, at 8:00 am

Fiscal Agent Prior Authorization Assistance

Available Dec. 1, 1998, at 8:00 am
Monday –Friday 8:00 am - 5:00 pm
Denver Metro (303) 534-0279
Colorado Toll Free 1-800-237-7647

EDI Support

Available Now
Monday –Friday 6:00 am - 5:00 pm
Toll Free 1-800-987-6721

CMERS

Available Nov. 30, 1998, at 6:00 am
Seven days a week, 24 hours per day
Denver Metro (303) 534-3500
Colorado Toll Free 1-800-237-0044

Fax-Back Eligibility

Available Nov. 30, 1998, at 6:00 am
Seven days a week, 24 hours per day
Toll Free 1-800-493-0920

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DADS**

**LEARN HOW TO LOCATE THEIR
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At Last!

Colorado Medical Society Member Services is able to offer wireless telephone service recommendations.

Through a memo of understanding, CMS Member Services is cooperating with **XEROGRAPHIXS WEST** 165 So. Union Blvd., Ste. 466, Lakewood, Colorado, to provide all types of both analog and digital cellular phone service.

Many features included and all ranges of cost, from turnkey programs including purchase of telephone and monthly "cover all" packages (pager, voice mail, email, two-line, caller ID, call forward, and more) as well as no roaming or long-distance fees (in Colorado) and a variety of air time programs.

For information on a wireless telephone system, call the CMS wireless communications consultant at

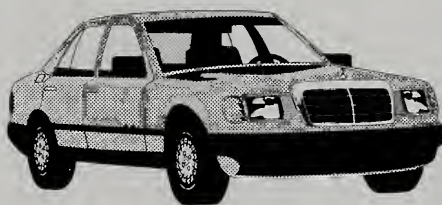
XEROGRAPHIXS WEST
- the most complete wireless communications provider we have found in Colorado.

**Telephone Gary Rayner
at 303-419-2789**

**or
303-980-6700**

You can leave a message on either phone and CMS is guaranteed a specialist will contact you within two hours on any working day.

A Unique Fringe Benefit For CMS Members



Buying or Leasing a New Car???

The **Colorado Medical Society** now provides a professional fleet management service to assist members throughout the state when purchasing or leasing a new vehicle. This service provides valuable vehicle information such as factory invoice costs, available options, technical data, consumer reports, etc.

Once your selection is firm, your purchase or lease will be arranged at **prices normally available only to large corporate fleets.**

Colorado Medical Society has endorsed Rocky Mountain Fleet Associates as a CMS member service, based on the satisfaction of the many physicians who have used their services over the past several years. These physicians have reported excellent results, **usually with savings of more than \$1000 from even the best negotiated showroom price.**

For more details, call **(800) 864-4388**. In Denver, **753-0440**.

Colorado Medical Society



AMA President speaks to Lectureship in Denver

*by Barbara R. Reed, MD
Colorado Alternate Delegate
AMA House of Delegates*

American Medical Association President Nancy W. Dickey, MD, was the guest speaker on October 2, 1998, at the Russell Pavilion in Exempla Saint Joseph Hospital, for the **10th Annual C. Houston Alexander Memorial Lectureship.**



Since this lectureship is in memory of an obstetrician-gynecologist, Dr. Dickey was asked to speak on the topic of women's health issues.

She cited statistics on the increasing number of

women in medicine. Today, she said, the number of women practicing medicine is 20%, and the number of women in medical school classes is around 45%. A growing number of schools report each year that the number of women in the entering class exceeds the number of men.

As women increase in the ranks of medicine, there will be a new perspective from and about women. This will influence the course of medicine, for medically-trained women will also at some time be patients. And so women will learn and teach medicine how they experience diseases, and how the diseases and the symptoms women

experience may be quite different from those of males.

But, Dr. Dickey went on to say, women's health issues may be viewed as an example of what will happen in medicine in general. For just as there are gender differences, or differences between men and women, so are there cultural differences which may influence the development and management of disease. Hispanics have a high rate of death from carcinoma of the cervix. Blacks have a high incidence of heart disease. And just as it is important that we learn about women's health issues, so it is important that we learn about cultural influences which influence the development of disease. We must also learn how lack of access to health care in cultures influences the development of disease.

Finally, Dr. Dickey emphasized that it is crucial that we find a way to deliver access to all patients. She stressed that it would not be enough for individual physicians to provide charity for patients. Though that is honorable, there are too many times when care is not given because it is too expensive. Further, there are times when a patient needs more than a single physician; perhaps there is a test to be done, or medications to be taken which are not given.

She complimented the physicians of Colorado for their work with the legislature in obtaining patient protections and lamented the death of the patient protection act in Congress in Washington.

CHPP elected officers and new Board members

Our own Sandi Maloney was reelected as President of CHPP. Other newly elected officer (listed from left to right as they appear in the photo below) include Marie Miller, R.N., Ph.D., Executive Director of Colorado's Area Health Educational Centers and Associate Professor of Nursing, School of Nursing at the University of Colorado Health Sciences Center, Vice President; Ida Walden, R.N., B.S.N., M.S.H.A., Executive Director of the Western Colorado Area Health Education center, Secretary; and Sharon Hart, Deputy Executive Director for the Colorado Commission on Higher Education, Treasurer.

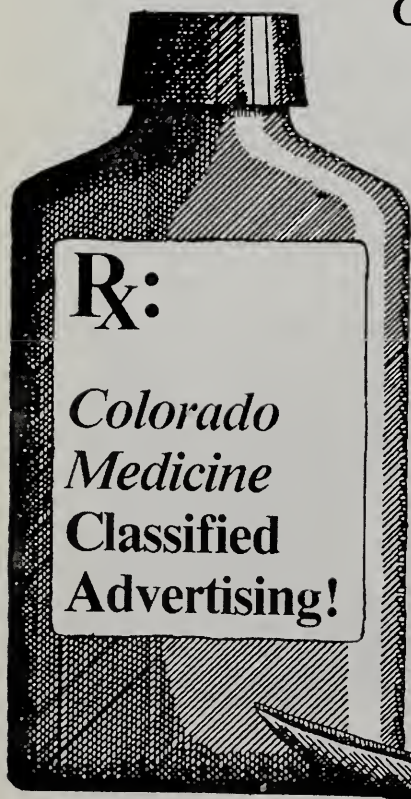
The CHPP is a collaborative composed of leaders in the health care industry. Founded by The Colorado Trust, its mission is to advance the creation of an integrated system develops adequate types and numbers of health professionals with the knowledge, skills and attitudes that meet the needs of Colorado communities.



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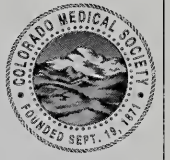
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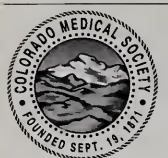
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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

***"Good health is merely
the slowest possible rate
at which one can die."***

Anonymous

We are in times of rapid change; it seems there's nothing changing more rapidly than the U. S. health-care system. I know you know that! Things that we have taken for granted for so long are changing overnight. It's happening all around us, and not only in medicine, but in business, political and social circles.

We've all pretty much accepted as fact that diet has a great deal to do with our longevity, yet diet standards are changing every day with new research and developments.

As the U. S. moves slowly but steadily toward a one-payer system of health care economics, I noticed the other day that the United Kingdom is slowly but steadily moving

away from a national health care system, saying quietly that it is inefficient, much too costly and not producing a lot of patient satisfaction.

Standards of education in the U. S. public schools are forever changing (even though one constant is the hue and cry for more money in the schools' budgets).

Styles are as changeable as the weather. Even in countries which are style-unconscious there is always change in social mores dictating style of living. One of the factors pushing this change is the ever-growing two-class system of "haves" and "have-nots".

Languages change. Typical of this rule is the expanding English vocabulary. Linguists say this is true of any language, which has to change to describe (or keep pace with) changes occurring around us.

Longevity is changing as well. Research and technical development in medicine has expanded life expectancy to the point that long life has become a problem on the other end of the spectrum: we're living too long. We're screwing up everything from attitudes to zoosterol.

Speaking of attitudes, there are some great international changes occurring. Many folks are developing an attitude about the U. S., including everything from "You are the only superpower; you clean up the mess" to "Mind your own business!"

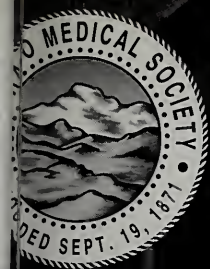
I suppose I'd be called a "conservative," but I am not sure what that label means any more. One of the more conservative

things I miss is regulation in areas of public utilities and commerce; e.g. deregulation of airlines, of most transportation, of communications, of banking, and so on. Bringing home the point was a recent airline trip and noting the changes which have taken place in this commerce because of deregulation. A lot of regulation was good and the U. S. did a good job of it, I thought.

Two people in front of me at the airline checkin counter almost came to blows because one man cut into line ahead of the other. Was this a result of deregulation? Yes, in one form or another. Socially, tempers and emotions are deregulated. Realistically, problems like this result from deregulation of airline route assignment and opening up of competition. More people are flying. Many social graces have been left behind.

I am finding that everything in my (and your) world is in a great state of change. The meaning of "U. S." (United States) has changed. Even we, who enjoy the finest standard of living on the planet, have undergone and are undergoing change in our attitudes toward this federation of states. And what is the meaning of the term, "patriotism"?

For many years, U. S. was interpreted as meaning "Uncle Sam," spokesman for democracy. I am reminded of what my son said when he was 5 years old: "Daddy, when did Uncle Sam die?" Who knows what inspired his question, but it has stayed with me these many years. I keep looking to helping Uncle Sam stay alive. However, he may be gone for good and "U. S." should stand for "Under Siege."

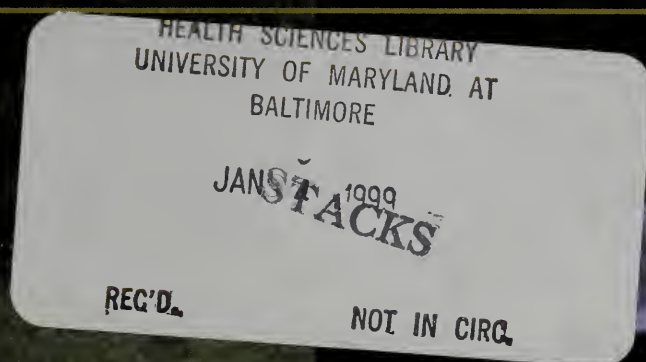


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Volume 95, Number 12



University of Maryland
HEALTH SCIENCES
JAN 10 1999



State legislature's bills, CMS
defy odds beginning their
year 2000 successful rural Colorado Health
resources

three Colorado rural locations in this "new
and" outreach program. See full report on page 405.

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Wartime Shortages by John L. Lightburn, MD, CMS Historian	page 412
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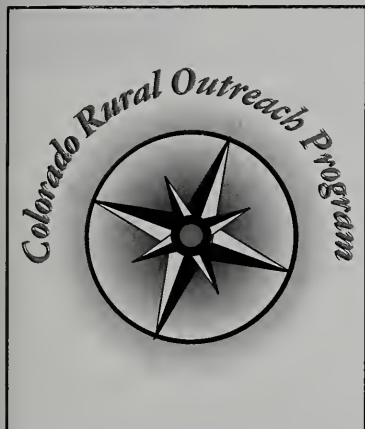
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December, 1998

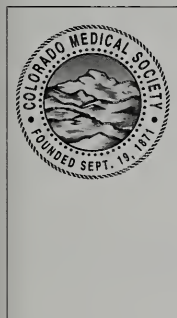
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Cover Story

CROP is designed to help rural Colorado stay abreast of medical needs. Haxtun's search for a physician turned up a candidate who had recently completed his residency.

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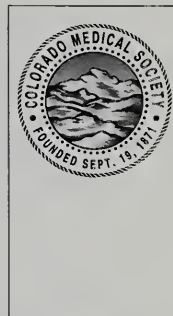


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PRESIDENT'S LETTER



W. George Shanks, MD
President, 1998-1999
Colorado Medical Society

A few months ago, I ran into a colleague at the hospital. Instead of her usual sunny disposition, she looked rather forlorn and I asked her what was wrong. Her tale was all too familiar. She had just attended another meeting, whether about Managed Care, Quality Improvement or Fraud and Abuse, and she was concerned for her future and the future of medicine. The requirements for documentation and pre-certification, as well as payment denials, were becoming insurmountable.

The conversation shifted to the clinical side of medicine when I gave her some follow-up on a patient she had referred with carcinoma of the colon. The good news was that this was a Duke's B carcinoma of the sigmoid colon with negative lymph nodes. This patient had an uneventful postoperative recovery and was discharged as an apparent cure.

All of a sudden, the smile came back to her face as she related her involvement. The patient had presented with some vague abdominal complaints. Although her history and physical were completely negative, a stool for occult blood was positive and an expeditious referral to the gastroenterologist established the diagnosis.

She had listened to her patient and used her clinical skills to rapidly and successfully establish a diagnosis that was truly lifesaving. She had not treated this patient with three months of Pepto Bismol or H2 blockers.

Her delight was fleeting, and as she left her sadness returned as her mind drifted back to the previous meeting. How was she going to face another day of 15 minute appointments with all these other issues gnawing at her psyche? Even if her mind didn't wander as she listened to her patients, would she be permitted to expeditiously implement the proper treatment course?

This doctor had just saved a life! Is this such a mundane occurrence in a physician's life that we afford it only a few moments of joy? In any other walk of life, the opportunity to save a life is extremely rare and when it does occur, one is treated as a hero and given the keys to the city. Was John Glenn's historic ride into space more important than this physician's early diagnosis of a potentially fatal disease?

We in the medical profession are relieving suffering, extending productive life and saving lives on a daily basis. These are the reasons that we toiled through medical school and residency. This is what our being is all about, and we do it extremely well. Let's spend some more time savoring our patient interactions and the large and small miracles that we perform each day.

Ten years ago a lot of our energies were devoted to dealing with Peer Review Organizations. This was followed by the question of the legitimacy and role of Health Maintenance Organizations in the delivery of health care. For-profit, E&M Documentation, Fraud, Waste and Abuse are issues presently being

Let's spend some more time savoring our patient interactions . . .

played out. Capitation, Risk & the Insolvency of Medical Management groups will dominate the coming year.

Our success as a profession in dealing with these issues and influencing their outcome is open to debate. The one constant in spite of all these attacks has been the doctor-patient relationship. I still see one patient at a time, in the privacy of my own office. The confidentiality of the encounter preserved and the appropriate treatment provided in spite of the obstacles. This has not changed during my thirty years in medicine. These are the issues that need to be preserved, the issues that bring us joy.

Spend a few moments reflecting on who you are and what you are doing. I believe you will be truly amazed and rightfully proud.

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legal counsel to the Colorado Medical Society

Hepatitis A Vaccine

The Colorado Department of Public Health and Environment will make hepatitis A vaccine available on a limited basis, beginning on January 1, 1999, through its Vaccines for Children Program. The vaccine will be made available in response to a December 1996 recommendation issued by the U.S. Public Health Service Advisory Committee on Immunizations Practices. The committee recommended that children and young adults in communities with intermediate and high rates of hepatitis A infection be immunized.

As a result in Colorado, the hepatitis A vaccine will be available to all eligible clients between the ages of 2 and 18 who reside in Adams, Arapahoe, Boulder, Denver, Jefferson and Weld counties. In Colorado from 1990-96, the six counties exceeded the national average for hepatitis A with 75 percent of the state's total cases during that period.

In other Colorado counties, the vaccine may be administered by providers to eligible clients between the ages of 2 and 18 who suffer from chronic liver disease; clotting factors disorders; to males who have sex with males; and to intravenous drug users.

In the case of a hepatitis A outbreak, the vaccine will be made available to any Colorado county where such an outbreak has occurred.

Eligible children are those who are either enrolled in Medicaid; uninsured; American Indian/Alaskan native; or underinsured (not insured for the vaccine) and vaccinated by a federally-qualified health center.

To obtain answers to questions about whether hepatitis A vaccine provided through the state Vaccines for Children Program may be used by a particular clinic or for a particular client, contact either Amy Warner, (303) 692-2673, or Rosemary Spence, (303) 692-2798, at the State Health Department.

Reminder! Medicare Eliminates Toll-free Transmission Lines 1/1/99

The Health Care Financing Administration's (HCFA) budget cuts for this year included the elimination of toll-free lines for transmission of electronic claims to the Medicare carriers. If you are currently filing claims electronically to Medicare you should have received information on this change from the EDI Support Services Department at Blue Cross and Blue Shield of North Dakota. *In order to continue to submit claims electronically after 12/31/98 you (or your vendor) must contract directly with a long distance carrier for these services.* If you have any questions you should contact Medicare's EDI Support Services at (701) 277-2655.

Interim Meeting 99 Educational Program

* Look for hotel and registration information in January's *Colorado Medicine*.

The Interim Meeting Educational Conference will be held on **Saturday, February 27, 1999**, at the Terrace Garden at Dove Valley, in Englewood.





Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

How to Stay Out of Litigation and How to Help Your Lawyer Once Suit is Filed

Kevin J. Kuhn & Patrick T. O'Rourke
Montgomery Little & McGrew, P.C.

No one likes to get sued. Lawsuits cause stress, take physicians away from their personal lives, and can lead to serious financial and professional consequences. Therefore, the best legal advice helps physicians avoid litigation altogether.

Top Ten Ways to Stay Out of Litigation

- 1. Good Documentation** - An old adage to remember is that "if it's not in the record, it didn't happen." A good chart, however, lays out more than just the physician's actions. A good chart is so complete that another physician could assume care for the patient tomorrow and understand the patient's needs and course of treatment.
- 2. Good Communication** - Many malpractice claims can be avoided or minimized by proper communication and informed consent. Informed consent requires the physician to advise the patient of any substantial risks of a surgical procedure *and* alternatives to the procedure. In all communications with patients, a physician should exercise candor and avoid technical language that the patient can't understand.
- 3. Good Consultation** - If there are a number of treatment alternatives available to the patient, offer second opinions to allow the patient to choose the course of treatment that will best serve his or her interests.

4. Accurate Representations - Do not engage in "puffery" concerning your background, education, and experience. A physician who misrepresents his experience to a patient will lose credibility in the eyes of a jury.

5. HMO Directed Medicine - It's no secret that many patients are dissatisfied with their managed care plans. Often times, they will transfer any frustrations with their HMO to their physicians. To avoid a conflict, you should remember two things: (1) the patient is your primary responsibility; and (2) the standards of medical care do not vary depending upon the method of payment or amount of reimbursement that a physician receives.

6. Attend to the Patient - When called from the hospital about a patient's condition, err on the side of caution when determining whether personal observation is necessary. Nothing could be worse for a physician than having to admit during a deposition that "I wish I would have seen the patient personally."

7. Adequate Discharge Instructions - Your discharge instructions should address areas of potential concern, including pain, wound care, and signs of infection. The instructions should also notify the patient who to contact if questions arise. Keep a copy of the discharge instructions in the patient's chart.

8. Record Prescriptions in the Chart - It shouldn't happen, but we regularly see physicians who fail to keep copies of prescriptions in the chart.

9. Maintain X-ray Films - The best way to prevent an argument concerning whether a diagnosis was correct is to keep a copy of the films that support it.

10. Prompt Responses - More than anything else, patients resent being ignored by their physicians. Although the demands of practice are great, you should make reasonable efforts to respond to your patients' reasonable requests. If you delegate tasks, make sure the delegatee is sufficiently trained to handle them.

Unfortunately, even if a physician observes all of these precautions, there is no guarantee that a patient will not file a lawsuit. If sued, there are several techniques that will maximize the benefits of the attorney-physician relationship and, hopefully, produce a favorable outcome.

Top Ten Ways Physicians and Attorneys Can Help Each Other During A Lawsuit

1. Observation - As attorneys, we can best help our physician clients when we understand the patient's care and treatment. Especially with surgical procedures, our understanding of the case is greatly enhanced if we can observe a subsequent operation.

CMS Med Fax

2. Process - Lawyers live in a different world than physicians. In a lawsuit you are likely to hear unfamiliar terms, such as "subpoena duces tecum," and "res ipsa loquitur." Your attorney should familiarize you with the legal process.

3. Attend Depositions - The physicians we defend are busy. Many decline to attend key depositions in their lawsuit, including the depositions of the patient and the expert witnesses endorsed against them. We strongly recommend that the physician attend these depositions.

4. Make Time - A lawsuit is a time-consuming process. We ask you to view the time you spend with your attorneys as an investment in your medical practice. We need your assistance and cooperation to conduct your strongest defense.

5. Emotional Impact - Traditionally, lawyers are known as attorneys and *counselors* at law. Although we are not therapists, we understand that lawsuits produce tremendous stress. Please tell us when the litigation process is producing anxiety. We've probably represented other physicians who have felt similar anxieties and can provide answers to the pressing questions.

6. Medical Education - Most lawyers are not physicians. We do not possess the specialized medical knowledge that our clients possess. In order to defend you, we need to learn the medicine involved in the case. Help us. Explain the procedure, its benefits, risks, and consequences. Point us towards medical literature that will advance our understanding.

7. Demonstrative Evidence - We live in a "show and tell" society. Jurors get bored by testimony. Physicians and lawyers should look for ways to bring the testimony to life. Models, charts, films, pictures, and demonstrations all serve this purpose. Help us identify opportunities to use them during your case.

8. Strategy - The physician should become his or her own harshest critic. By examining the patient's care as critically as possible, the physician demonstrates the areas in the case that the opposing counsel will likely try to exploit.

9. Preparation - Before you testify at trial or deposition, your attorney should thoroughly prepare you for the experience. Good preparation will allow you to most effectively withstand cross-examination. If your attorney doesn't suggest it, ask if your preparation sessions can be videotaped for your review.

10. Choice of Forum/Resolution - In theory, lawsuits take place in the courthouse. In reality, there are many fora in which a legal dispute can be settled. Your attorney should counsel you about alternatives to litigation including arbitration and mediation. Settlement is also a possibility. If you decide to settle a lawsuit, it could have negative consequences, including reporting to the National Practitioner Data Bank, investigation by Boards of Medical Examiners, restriction of medical staff privileges, and loss of HMO participation. Your attorney should discuss these possibilities with you *before* settlement.

We know that these tips won't make the litigation process enjoyable, but we hope that they improve your relationship with your attorney and increase the possibility that any lawsuit against you will be resolved in your favor.

Help for Medicare Patients Wanting More Information About Program Changes

HCFA's mailing of a bulletin titled, "Medicare & You" has prompted seniors to call help lines for answers about the Medicare+Choice changes scheduled to begin in 1999. (See article in November 1998 MedFax for more information.) If your patients turn to you for help, you can let them know that the following resources are available: Centura Senior Resource at 1-800-544-9181 or Colorado Division of Insurance at (303) 894-7499 ext. 356. CFMC has printed information on the Medicare options available by calling (303) 695-3300 ext. 3050.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the contact at the end of the listing.

2nd Annual Diabetes Conference "Think Like a Pancreas"

Friday, December 4, 1998

Antlers Doubletree Hotel

Colorado Springs, Colorado

Contact: Jan Hodge – Memorial Hospital (719) 365-5675

7th Annual Bugs and Drugs in the 90's

December 11 and 12, 1998

Contact: Gina Liscum – UCHSC

phone (303) 372-9050, fax (303) 372-9065, or e-mail

Regina.Liscum@UCHSC.edu

Fractures Below the Belt

January 14-16, 1999

Eldorado Motel

Santa Fe, New Mexico

Contact: CMS Office - Texas Tech University Health Sciences Center (915) 545-6685

30th Annual Cardiovascular Conference at Snowmass

January 18-22, 1999

Snowmass Conference Center

Aspen/Snowmass, Colorado

Contact: Registration Secretary, Extramural Programs – American College of Cardiology (800) 253-4636 ext. 695

22nd Annual Winter Symposium "Anticipating the Future"

January 22-23, 1999

Grand Junction Country Inn

Grand Junction, Colorado

Contact: Patrick Moran, MD – St. Mary's Hospital (800) 458-3888 ext. 2004

5th Annual Pediatric Symposium "Growth & Challenges in Office Based Medicine"

Saturday, January 23, 1999

Sheraton Colorado Springs

Colorado Springs, Colorado

Contact: Jan Hodge – Memorial Hospital (719) 365-5675

Clinical Diabetes & Endocrinology

January 24-28, 1999

Snowmass Conference Center

Aspen/Snowmass, Colorado

Contact: Donna Loy (303) 789-9682 or (800) 421-3756

Ski & CME Midwinter Conference

February 21-26, 1999

Keystone Lodge & Resort

Keystone, Colorado

Contact: Patricia Ellis – Colorado Society of Osteopathic Medicine (303) 322-1752 or (800) 527-4578

25th Annual Vail OB/GYN Conference

February 21-26, 1999

Vail, Colorado

Contact: Linda Woodstock – UCHSC

phone (303) 372-9050 or fax (303) 372-9065

The 6th Annual Echocardiographic Workshop on 2-D & Doppler Echocardiography at Vail

February 22-25, 1999

Vail, Colorado

Contact: Registration Secretary, Extramural Programs – American College of Cardiology (800) 253-4636 ext. 695

CRASH 99: Colorado Review of Anesthesia & Ski Holiday

February 27 - March 5, 1999

Contact: Phyllis Tuller - UCHSC (303) 372-6301 or

<http://www.uchsc.edu/sm/anesth/crash.htm/>

CHA's 3rd Annual Patient-Centered Satisfaction User's Meeting

March 4-5, 1999

Englewood, Colorado

Contact: Michael Boyson – Colorado Health & Hospital Association (303) 758-1630

Horizons in Surgery, presented by Department of Surgery CU School of Medicine

March 6-13, 1999

Breckenridge, Colorado

Contact: Sara Ellis (303) 315-5571

80th Annual Session American College of Physicians - American Society of Internal Medicine (ACP-ASIM)

April 22 - 25, 1999

New Orleans, Louisiana

Contact: ACP-ASIM Customer Service – American College of Cardiology (800) 523-1546

4th Annual Clinical Cardio Mgnt. & Diagnostic Dilemmas

April 28-30, 1999

Eldorado Hotel

Santa Fe, New Mexico

Contact: Registration Secretary, Extramural Programs – American College of Cardiology (800) 253-4636 ext. 695

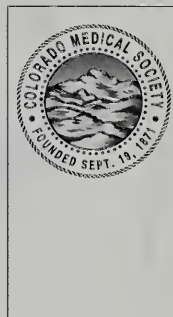
Send us your calendar items.

If your specialty society or hospital is sponsoring a CME event or seminar which would be of interest to physicians in Colorado, send the information to: Event Calendar, *Colorado Medicine*, P.O. Box 17550, Denver, CO 80217-0550. Please include program sponsor, date, location and phone number for more information.

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society



Hey, AMA ... no need to reinvent the wheel!

I was very interested in seeing the announcement by the American Medical Association that it hopes to improve the way medical mistakes are reported, investigated and analyzed. AMA President Nancy Dickey, MD, said "We have to change the culture." She went on to say that "I think you'll see something that parallels the aviation safety reporting system without finger-pointing or blaming."

That's fine. But let me tell you about what's been going on here in Colorado for the past 20 years that has become one of the state's best kept medical secrets.

The secret is "Copic Risk Management." Oh yeah, everyone has a damage control department (few major corporations would be without one these days), but they are a team that reacts after the damage has occurred or is occurring. In our case with Copic, the prospects of damage are assessed long before any real damage can result, and the experts swing into action to prevent such potential damage from affecting any other patient or physician.

What does this have to do with what Dr. Dickey said? She said she thought the evolving system would be like the aviation system: reporting near misses and finding out why a near miss occurred, then training or taking steps to prevent such an incident from repeating.

The AMA can learn a lot about this from the Copic Insurance Risk Management system, which is over 20 years old. It was started by Dr. Robert Brittain when he was a one-man business called Medical Liabilities Consultant Program

(MLCP). Bob recognized the importance of looking at trends in possible malpractice incidents BEFORE they ever developed into an insurance claim. This process did two things: it made the Doc much more comfortable dealing with an insurance company.

The next thing Bob did was to start a frequent newsletter called "Copiscope" which pounded on the doctors to call in any incident which occurred in their practice they had any question about. As a result, Copic has a 19-year-old "Incident Report database" that covers thousands of these reports, NOT CLAIMS, mind you, but reports direct from physicians telling what happened and how it happened. Now **that** is a valuable database. The aviation people call this their "Near Miss database". I did a little checking around and found out that today Copic Insurance receives on average 320 incident reports per month. Some Docs call if they have a patient who is a slow payer; others don't think they are at risk and don't call in enough. Copic won't shut off anyone or any type of incident report. Copic doesn't use a "Claims Clerk" to take the report; they have two Registered Nurses who take the initial report and since they receive as many reports as they do, they can see the same kind of incident occurring many times over and, from their experience, know how to handle the gathering of the vital information.

If that incident report looks like a highly probable claim, the report goes to any one of four physician specialists who handle these matters,

and they don't hesitate to forward the report to another specialist who can give them a very objective opinion on the reporting doctor's file.

Bob Brittain knew what he was doing when he started these two procedures, and today, "Copiscope" is one of the most valuable tools the physician has in preventing "near misses". Copic Risk Management keeps hammering on everyone to "call home" with that incident report. "Doctor, you don't need to fret; no one is going to be judgmental, accusatory or acrimonious when you call," they say. And it's true!

Here's an interesting sidelight on the Copic incident report database: only one-seventh of those reports ever become a claim. The first thing that comes to mind is that Copic must learn a lot from those reports in that group. Wrong. Claims are not indicative of the root of the problem. The Risk Management folks say they learn a lot more from the six-sevenths reports that were just "near misses" because they give Copic indication of trends or tendencies. Copic can warn all the other doctors what to watch out for. Dr. George Thomasson calls this group their "Early Warning System."

I strongly urge the AMA to look at the one-of-a-kind risk management program at Copic Insurance. AMA says it wants a new system of reporting, investigating and analyzing medical mistakes. "What we're talking about," said Dr. Dickey, "is creating a system where we can see what's going wrong." Copic has a system where they can see what's going wrong ... and help fix it.

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Board Profile:

Colorado Medicine begins a year-long introduction to the Colorado Medical Society Board of Directors.



John V. Buglewicz, MD

Dr. John V. Buglewicz, a native of Omaha, NE has been in family practice in Florence, CO since 1961. He took his medical degree at Creighton University. He represents CMS

District III, Southeast Rural, made up of the following counties:

Park	Chaffee	Fremont
Saguache	Custer	Hinsdale
Mineral	Rio Grande	Baca
Alamosa	Conejos	Costilla
Huerfano	Las Animas	Bent
Otero	Crowley	Kiowa
Prowers		

CMS District III covers the largest surface land area of any of the ten CMS districts. Dr. Buglewicz has been a member of the Fremont County Medical Society, the CMS and the AMA for 37 years. He has been on the CMS Board since January, 1996. Dr. Buglewicz is in Senate District 4 and State House District 44.



Alan D. Rapp, MD

Dr. Alan Rapp practices in Colorado Springs and has been a CMS member since 1960 and board member since 1995. He represents District X, which is Teller and El Paso

Counties. Dr. Rapp specializes in Cardiology, Internal Medicine and Aerospace Medicine. He was born in Shenandoah, IA and graduated from medical school at the University of Chicago, with internship and residency at the University of Illinois Hospital Center. He is currently a member and has chaired the CMS Council on Legislation. Colorado Springs is in Senate District 10 and State House District 15. Dr. Rapp is also a CMS Legislative Key Contact.

Dr. Rapp is currently President of the El Paso County Medical Society.

Congratulations to



Eugene D. Jacobson, MD

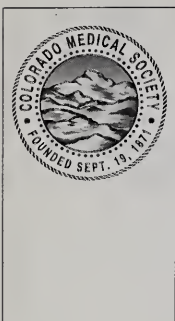
... for his appointment to the American Medical Association Continuing Medical Education Advisory Committee for the calendar year 1999.

Dr. Jacobson was appointed by the AMA Board of Trustees effective in October, 1998. He was notified of the appointment by E. Ratcliffe Anderson, Jr., MD, Executive Vice President of the AMA. In his announcement, Dr. Ratcliffe said the committee "is a committee of the AMA Council on Education, and has two principal functions". He said "The first is to review and recommend to the Council on Medical Education acceptance, rejection or modification of proposed changes in the standards for the accreditation of continuing medical education programs. The second is to review and recommend to the Council on Medical Education policy positions related to continuing medical education either on the Continuing Medical Education Advisory Committee's initiative or as requested by the Council on Medical Education." Dr. Ratcliffe continued, saying "It is critical to have members who possess outstanding qualifications such as yourself."

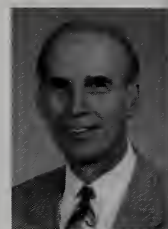
Dr. Jacobson is a member of the faculty at the University of Colorado Health Sciences Center. His specialty is Gastroenterology. Dr. Jacobson has been active in many CMS activities, principally as a Denver Medical Society delegate to the CMS House of Delegates and a delegate to the AMA representing the American Gastroenterological Association. He currently is a member of the Denver Medical Society Grievance Committee and has served on that committee since January, 1993. His term ends in 1999. Dr. Jacobson has been a member of the Denver Medical Society Long Range Planning Committee, and is also chair of the CMS Grievance Committee and a member of our Long Range Planning Committee.

Dr. Jacobson was at one time Dean of the University of Colorado Medical School, but stepped down from that position to resume his teaching position in gastroenterology.

Dr. Jacobson's term is for one year, beginning January 1, 1999.



MEDICAL EXCHANGE



Gary D. VanderArk, MD
Medical Editor

There is a lot of help and expertise available all you have to do is ask.

"The computer revolution, it seems, is leaving doctors behind" trumpeted the Denver Rocky Mountain News on November 8, 1998. This item was in response to an article in the October 21, 1998 JAMA by Hersh & Hickam entitled "Physician Use of Electronic Retrieval Systems." This study found that online searches turn up only 25 to 50% of the relevant articles on a topic, and typically take 30 minutes.

As the media seems prone to do, the "Rocky" failed to note the encouraging news in the same issue of JAMA concerning Clinical Decision Support Systems (CDSS) and their ability to improve clinical practice and quality of care. The good news is that the number and quality of studies of CDSSs are increasing and in certain clinical areas, such as drug use and preventative medicine, these systems have been shown to improve physician performance and improve patient outcomes. CDSSs will increasingly effect medical decisions.

The computer revolution is not going to leave doctors behind if Jeff Rose, MD has anything to say about

it. Jeff heads up the effort being made by Kaiser Permanente in Colorado to maximize the benefits of computers in enhancing medical care. Don't miss Jeff's article entitled "Medicine and the Information Age" in this issue of *Colorado Medicine*. Read it and you will be stimulated to do things differently in your practice.

When it comes to computers and medicine, I think most of us need some kind of help. When you need help you can turn to the Colorado Medical Society. Our Medical Informatics Committee exists to "explore current issues in the arena of medical informatics and provide necessary information to members of the CMS." The committee is chaired by Mike Victoroff, MD and members include: Joe Dwoskin, MD; Claude Poliakoff, MD; Rich Quinn, MD and Dennis Waite, MD. They were vitally involved in the Medical Informatics Fair at the Denver Medical Library and they recently completed Saturday morning tutorials that hardly any of you attended. There is a lot of help and expertise available all you have to do is ask.

Isn't there some alternative? I didn't think there was until my practice received the following memo from our practice administrator:

Due to the number of problems that employees have been having with their computers, all PC's will be removed from our offices by Friday. All employees will instead be provided with an Etch-A-Sketch.

There are many sound reasons for doing this:

1. No Y2K problems
2. No technical glitches keeping work from being done
3. No more wasted time reading and writing e-mails
4. No more wasted time and frustration rebooting many times a day
5. No more wasted time and money maintaining a network
6. Electric bill will go down

Frequently asked questions for Etch-A-Sketch technical support:

- Q:** My Etch-A-Sketch has all of these funny little lines all over the screen.
A: Pick it up and shake it.
- Q:** How do I turn my Etch-A-Sketch off?
A: Pick it up and shake it.
- Q:** What's the shortcut for "Undo"?
A: Pick it up and shake it.
- Q:** How do I set the background and foreground to the same color?
A: Pick it up and shake it.
- Q:** What is the proper procedure for rebooting my Etch-A-Sketch?
A: Pick it up and shake it.
- Q:** How do I delete a document on my Etch-A-Sketch?
A: Pick it up and shake it.
- Q:** How do I save my Etch-A-Sketch document?
A: Don't shake it.

Thank you for your support of this new direction in technical support.

CROP – A good investment!



Haxtun, Colorado, is not far away in miles, but when there's no medical service in this eastern Colorado town of 1,100 residents, Haxtun feels a long way from anything. The town is, as the crow flies, about as far northeast from Denver as Walsenburg is to the south, to Silt on the western slope, or to Chugwater, north of Cheyenne, Wyoming. Haxtun's health care situation is not so much location as it is the fact that it has an aging population in the Haxtun Hospital District with, until recently, only one physician on staff. He is about to retire.

Enter Colorado Rural Outreach Program (CROP), the program element of the Colorado Medical Society Foundation, designed to help rural Colorado stay abreast of medical needs. Haxtun's search turned up the most likely candidate, a new physician who had recently completed his residency program but was faced with a large medical education loan to repay. Dr. Jose R. Hinojosa, a 1994 graduate of the University of Iowa who has just completed his family practice residency at Fort Collins, is the new physician at Haxtun District Hospital. Between CROP and the town of Haxtun, \$20,000 has been granted toward loan repayment for him.

Dr. Hinojosa is from Edinburg, Texas. His wife, Yvonne Hinojosa, is also an M.D. and will be practicing one day per week. Dr. Jose Hinojosa is under a one year contract to practice in Haxtun, and the hospital is currently working on a contract for two more years, further paying down his loan. The Haxtun hospital



A proud and pleased group gathered recently at the Haxtun District Hospital where Jack Berry, MD, (r) met with Jose Hinojosa, MD (l) and Hospital Administrator Jim Brundige to announce the CMS CROP award of \$10,000 toward Dr. Hinojosa's medical education loan repayment.

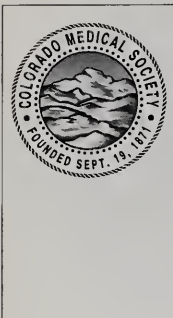
requested CROP provide loan repayment assistance of \$10,000 per year for three years. The hospital would commit to matching funds totaling \$10,000 for the three years. CROP has awarded \$10,000 for one year, and the second and third years remain negotiable.

Hospital Administrator, Jim Brundige, said another physician from the Fort Collins residency program, Dr. Gregory Holst, now practices in Haxtun. Dr. Holst is receiving federal loan repayment assistance.

Haxtun is in Phillips County, Colorado, designated by public health authorities as one of the state's most chronically medically underserved areas.



Dr. Jose Hinojosa examining one of his patients in the Haxtun District Hospital, after CMS CROP pledged to help repay his medical school loan. Haxtun matched CROP's one year pledge of \$10,000 with the option to extend his contract.



CMS EDUCATIONAL FOUNDATION*



John F. Farrington, MD
Chairman
CMS Educational Foundation

Report to the 1998 Annual Meeting on the Colorado Medical Society Educational Foundtion

Thank you for this opportunity to provide a thumbnail sketch of the activities of the Colorado Medical Society Education and Research Foundation.

I hope this will be the last time I refer to CMS/ERF. I will make a recommendation to the Board of CMS/ERF that its name be changed to the Colorado Medical Society Education Foundation. This more closely fits our mission.

CMS/ERF has two major activities: 1) To provide financial support to the Colorado Science and Engineering Fair through a \$1,000 yearly donation. 2) Identify deserving students and by awarding scholarships, remove some of the financial stress that frequently accompanies their first year at the Health Sciences Center.

There are so many outstanding applicants seeking aid that it is very difficult for the Foundation to select the finalists, much less reduce this number down to two or three deserving individuals who will

receive our financial support. This year the Foundation received 26 applications, just over 10% of the first year class. Based on scholarship, community service, dedication to medicine, motivation, financial need and expressed desire to settle in an under-served area, we awarded scholarships in the amount of \$5,000 to each of three outstanding students. The recipients were:

Wendy Ahlbrandt, born in Grover, CO, population 150, a town so small that it does not appear on the state map. She has deep roots in rural life. She seeks a career that will give her a sense of purpose, a career that she will enjoy and take pride in,

a career that is beneficial to others as well as to herself.

Michael Sloan was born in Rocky Ford, CO, and grew up in Alamosa. Mr. Sloan spent nine years in the United States Navy where he made it his personal goal to help many young men and women guide their future in a structured and positive manner. Mr. Sloan is a member of the Cherokee Nation and ultimately wants to work under the Bureau of Indian Affairs.

James Yerger was raised in Custer, MT, a town of 300 with no physician or ambulance service. He learned at an early age the hardship of living in a community with

CMS/ERF Expenses against Year-end bank balance

Year	Year-End Balance	Expenses
1989	\$ 35,071.00	\$ 9,520.00
1990	28,329.00	3,263.00
1991	44,093.00	0
1992	44,215.00	540.00
1993	55,783.00	2,825.00
1994	49,564.00	5,800.00
1995	49,207.00	10,525.00
1996	46,350.00	11,080.00
1997	43,215.00	11,025.00
1998	35,046.00	16,000.00

* formerly Colorado Medical Society Education & Research Foundation (CMS/ERF)

extremely limited access to health care. He witnessed the sorrow associated with untreated serious disease and wants to dedicate his practice energies in caring for people in a rural setting.

There is another young lady I want to bring to your attention. Katie Probst is the 1998 winner in the medical division of the Colorado Science and Engineering Fair.

The chart on the preceding page is a record of our expenditures compared to our year-ending cash balance over the past several years. As you can see our resources are very limited but the impact we have made on several young lives is great.

The activities of the CMS Education Foundation are dependent on two primary sources of funding. First, CMS donates \$25 in memory of each member who has died during that year. Fortunately for those of us the older age groups, this source of income has been somewhat limited during the past several years. The second major source of income is from contributions made along with your dues. We would encourage each CMS member to make this voluntary tax-deductible contribution. Your dollars do count; they will make the difference for deserving students during their first year at the Health Sciences Center.

We have opened communication with the Montana and Wyoming Medical Societies and will be asking for their help in supporting applicants from their states.

We will also be contacting specialty organizations within Colorado asking for their help on a regular basis.

If any CMS member wishes to provide a memorial for a family member, patient or a colleague, the CMS Education Foundation may be just what you are looking for.

As I mentioned, our resources are limited, the need is great and small contributions are what have always sustained us. We certainly wouldn't turn down a million dollar gift—a \$50 gift from each of the CMS members would do even more. Help support the future of your profession by supporting these young student physicians.

Please keep your Education Foundation in mind as part of your charitable giving plans.

Highlights of Board of Directors Meeting – November 20, 1998

- A. Copic: Dr. Buckley stated that Copic has received quite a few calls regarding "Operation Restore Trust" (dealing with insurance fraud and abuse). Copic's Board of Directors has offered to work with CMS to provide correct information to physicians, and assist them with their best course of action.
- B. CMSA: Ms. Leslie Nathan stated that the Alliance has been focusing on communication with the county alliances. She invited the board to attend their annual meeting on April 20, 1998, at the Broadmoor in Colorado Springs.
- C. AMA Delegation: Dr. Rich Quinn reported. He stated that the delegation is getting ready for the AMA Interim Meeting in Honolulu, Hawaii, December 6-9, 1998. The handbooks for the meeting are being reviewed by the delegation. He reported that CMS staff has put forth a lot of effort on behalf of Dr. Joel Karlin's campaign for the AMA Board of Trustees. A report from the Committee of Governance and Structure has been distributed to the delegates. This report deals with how the AMA has misdealt with some problems, and will be discussed at reference committee during the interim meeting. The E&M Documentation Guidelines will also be discussed during the meeting.
- D. Medical Executives Group: Donna Foss reported that the executives are looking forward to the Interim Meeting Educational Session. Ms. Edie Register and Ms. Marilyn Rissmiller presented an update on the Hassle Factor Project to the Medical Executives. They will continue to urge their physicians to send documentation to CMS for this project.
- E. Colorado Rural Outreach Program (CROP): A letter from the CMS Foundation Board (CMSF) was presented to the Finance Committee, requesting that the indebtedness to CMS of the line of credit given to CROP be forgiven. The Finance Committee approved referral to the Board. After lengthy discussion, the Board approved forgiveness of this line of credit. This will allow CMSF to approach potential donors as a debt free entity, thus assuring the donors that 100% of their donation will go toward recruitment and retention of rural physicians.

The next CMS Board meeting will be held on January 22, 1999 at the Colorado Medical Society offices.



David C. Martz, MD
President, CPN

According to Carl Nagle, Marketing Director for RMHMO, the Front Range is at last on the verge of major growth in enrollment. The following comments are abstracted from his presentation at the CPN Annual meeting on October 31:

1. Despite termination of about 2000 Medicaid patients, RMPC net membership has increased from 4,000 to 8,000 participants from January 31 to September 30, 1998.
2. During this period, marketing has been focused in the Greeley and Pueblo regions.
3. With the advent of the Millennial relationship we will begin to focus on Metro Denver as of January 1, 1999.
4. We have projected approximately 13,000 new members in the front Range for 1999.
5. The new "Open Access Point of Service" Plan is being received very positively in the managed care market.
6. RMHMO has budgeted for a significant increase in resources in 1999 to underwrite aggressive marketing on the Front Range.

Finally, Carl clearly states that "we would not be experiencing all of this success without the support and help of CPN." Our thanks to Carl, his associate Mark McCain, and the leadership and staff of RMHMO for these exciting accomplishments!

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Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Time to Check Out the Copic Web Site

The end of the year seems a fitting time to look toward the future. For more and more companies these days, a significant part of that future is going to take place on the World Wide Web. This is true as well for Copic Insurance Company. We're extremely pleased that you are visiting the site and finding it useful. According to the most recent statistics we've gathered from <http://www.copic.com>, many of you are taking advantage of this rich resource.

For the period: August-October, 1998

Average number of user sessions each weekday: 115

Average number of user sessions each weekend: 168

Five most requested pages:

1. Caution: Vicodin Toxicity (www.copic.com/csonline/cs000094.htm)
2. Adverse Effects of Topical Steroids (www.copic.com/csonline/cs00151.htm)
3. Flexible Sigmoidoscopy Consent Form (www.copic.com/guidance/sigmoid.htm)
4. Laparoscopic Cholecystectomy and CBD Injuries (www.copic.com/csonline/cs00070.htm)
5. Practice Quality site visit handout (www.copic.com/pquality/pq.htm)

Five most downloaded files:

1. June issue of Copic Topics newsletter (www.copic.com/thisjust/ct-0698.pdf)
2. Colorectal Cancer Screening Guidelines from the CCGC* (www.copic.com/links/crcscreen.pdf)
3. Care of the Adult Patient with Diabetes from the CCGC* (www.copic.com/links/diabetes.pdf)
4. Colorectal Cancer Screening Flowchart from the CCGC* (www.copic.com/links/crcgrid.pdf)
5. Copic's Guidelines for Breast Lumps and Lesions (www.copic.com/guidance/br-gdln.pdf)

* Colorado Clinical Guidelines Collaborative

Most active hour of the day: Noon to 1:00 p.m.

% of users during work hours (8 a.m. to 5 p.m.): 62%

% of users after work hours (5 p.m. to 8 a.m.): 38%

Five top search keywords:

1. Vicodin
2. sigmoidoscopy
3. stenosis
4. spinal
5. cholecystectomy

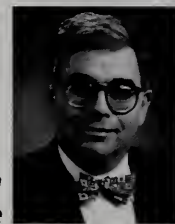
If you've never visited the site -- or if you haven't visited in a while -- I'd like to call your attention to some of the other features and resources you can find at <http://www.copic.com>.

- **Looking to earn ERS points?** At www.copic.com/seminars/seminars.htm, you can search from among ten types of seminars to find one that fits your schedule. Online registration is available for all seminars held at Copic offices, as well as for many seminars for which Sue Turek of our Risk Management department is the official contact. For those of you not yet connected to the Internet, you can always find the seminars in Copiscope, or you may contact Sue directly at (303) 930-0437 or (800) 421-1834, ext. 2437. In the near future, you can also look here to learn more about the disease-state management presentations to be offered through EPIC (Equal Partners In Colorado Care).
- **Don't know where to find other web sites of interest?** Check out our "Link Library" at www.copic.com/links/links.htm. You'll find a selection of hot links to sites grouped into categories such as Government Resources, National Medical and Specialty Societies, National Voluntary Health Organizations, Other Physician Resources, and Patient Resources.
- **Searching for a procedure-specific consent form that will meet with Copic's approval?** Then you shouldn't miss this section of the site, located at www.copic.com/guidance/forms.htm. You can view and print forms for allergy injections; blood and blood products; chemotherapy; flexible sigmoidoscopy; opioid medications; preauthorization to treat children; steroid therapy; surgical procedure; office procedure; and vasectomy, as well as model record release and clarification of record request forms.
- **Need to get to our offices?** Here are some easy directions: go to www.copic.com/seminars/map.htm and click on "Print." You'll get a handy map and step-by-step driving directions.

We are always open to suggestions for additional content and features. Contact Marjorie Wallwey, Webmistress, at (303) 930-0467 or (800) 421-1834, ext. 2467. If you prefer to use e-mail, drop her a line at webmistress@copic.com.

SOS (State of the School)

Richard D. Krugman, MD, Dean
University of Colorado School of Medicine



CU School of Medicine Completes Year of Accomplishments, Challenges

This past year has been one of the more difficult and stressful in recent history for schools of medicine in the United States. Research and clinical enterprises were such that nearly everyone needed to work longer and harder just to stay even.

The challenges for the University of Colorado School of Medicine were no less stressful. Add in the internal debate surrounding planning for the move to the Fitzsimons campus and one might say it was worse that a triple "critical" in biorhythms. Some would say this period has been going on for two years.

Yet, during that same two-year period, the School has made some very positive strides. Here's a baker's dozen that come to mind:

1. We revised the promotion and tenure rules that eliminated a two-class system that was increasingly demoralizing to the faculty.
2. The successful recruitment of Richard Spritz in Genetics fulfills a decade-long effort to bridge the archipelago-like genetics programs in our School and community.
3. Pharmacology became the number one department of all U.S. medical schools in NIH funding.
4. Physiology attained a goal of at least one RO1 multi-year research grant for all but one faculty member and that faculty member nearly single-handedly coordinated curriculum of the entire first-year of medical school.
5. The successful recruitment of an

academic head for the Department of Pathology ended a decade-long drought in cooperation between the School and Children's Hospital in this area.

6. Preventive Medicine, many of the divisions of Medicine, and sections of Surgery, Pediatrics and Psychiatry all have seen significant growth in their research funding and/or have recruited promising faculty and division heads.
7. Seven endowed chairs have been added in the last two years, an equivalent of nearly \$500,000 in general fund support to the School.
8. Progress in education under the leadership of Dr. Jerry Merenstein, Senior Associate Dean for Education, has been terrific.
9. Our pre-clinical students and CU dental students have excelled on the basic sciences portion of their licensure exams, with a 100 percent pass for both, and dozens of individual faculty were nationally recognized.
10. The multi-disciplinary centers – Cancer, Neurosciences, Molecular Biology and Nutrition – had very positive external five-year reviews and continue to grow.
11. Our clinical enterprise continues to excel. University Physicians, Inc. (UPI) grew to \$97 million in revenue, and our seven-year strategy of developing health plans looks pretty good now compared to other medical schools in the U.S. who are losing money on the hospitals or practices they bought.

12. Many of the clinical programs, such as solid organ transplant, are nationally ranked with superb outcomes. Many of our clinicians are considered among the best doctors in America.
13. And, finally, we successfully began the transformation of the Fitzsimons master planning process.

Meanwhile, the difficulties of the past year have, I believe, caused us for a sustained period of time to stray from our academic mission. It made many of us question whether we had the resolve to carry out our mission. I think we do. Let me share my vision for the four areas of our mission:

First, we are at another key time in medical education. In 1990, we agreed to balance our success in research and specialty training with more emphasis on primary care. We have been very successful in that endeavor. Our number four ranking in primary care, the CCHE Award of Excellence and legislative support are testimony to that success.

Now it is time to rebalance again. I worry about the shrinking pool of students who will be our replacements on this faculty. The School will create an initiative to find ways to encourage more of our students to go into academic medicine. I expect this academic medicine initiative to be as successful as our generalist initiative of 1990.

Secondly, in research, I believe we need to be more technologically advanced and maintain the collaborative and interdependent nature of our enterprise that has had so much

to do with our success. Maintaining that on a split campus will challenge us, but we will get it done. In the past two years, we have begun linkages to the engineering schools, biotech firms and the aerospace industry. We are going to need to create opportunities, not just wait for them to happen.

My clinical vision has us ultimately on the same campus with our major affiliates. It has us providing patient-centered care. Such care creates some hassles for the physician, but such hassles are dwarfed by the rewards and pleasure of our patients' gratitude and hearts.

We need to begin this effort now, including here at University Hospital and The Children's Hospital, by the way.

Finally, we need to continue our community service. If we ever hope to have state help for all we need to do, we must continue to meet what the state perceives it needs from us. We need to keep up this part of the School's mission and adapt to Colorado's changing needs.

For the past eight years, I have traveled the state and trumpeted about what a terrific place this is. It is terrific for three basic reasons: a terrific faculty, a terrific student body (including residents, graduate students and fellows) and terrific programs.

We have had a sustained growth and development that is the envy of many schools, including some ranked ahead of us. We have enjoyed tremendous success in cancer, neuroscience, molecular biology and nutrition over the past decade, and are poised to do so in molecular structure and health outcomes.

The internal debate concerning the move to Fitzsimons, in my estimation, is over and it is time to get on with our opportunities while confronting and mitigating the challenges that face the School. We cannot afford to not develop the 500,000 square foot ambulatory care and cancer center, and eye institute space at Fitzsimons. We cannot afford to not fill an additional

600,000-800,000 square feet of research space. And we need to use the opportunity of new research space to build on our existing strengths and find new areas to explore.

We are blessed with excellent chairs and excellent center directors. As a School, we cannot function without the structure that strong chairs and departments provide us. We are going to need every one of those chairs and center directors, and every faculty member to be willing to take risks again. It is ironic, but true, that programs, department and schools that are risk-averse, do not thrive in this or perhaps any academic environment.

I have been reassured over the last several months that we are refocused on carrying out our academic mission at the School of Medicine. To paraphrase a colleague of mine in California, "We are surfing the sine wave of life." We've finished the downward segment, which was rough, but I believe we have survived it and are ready to arc upwards again.



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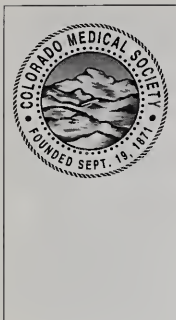
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Correction

CMS Delegate Attendance of the
128th Annual Meeting

William L. Doig, MD attended
representing Clear Creek Valley
Medical Society.



John L. Lighburn, MD
Historian, Colorado Medical Society

"It is perfectly true, as philosophers say, that life must be understood backward. But they forgot the other proposition, that it must be lived forward."

Kierkegaard

Seven weeks before the Japanese bombed Pearl Harbor, James J. Waring took temporary leave of his professorial duties at the School of Medicine to take a light hearted journey to Skytop, Pennsylvania to deliver his presidential address to the American Clinical and Climatological Association. The title of his address was, "Anatomy of Angling". He congratulated the association for choosing a sylvan setting for a meeting rather than a metropolitan center "where scientific medicine is often dispensed in indigestible quantities." In his address, he praised the wisdom of Izaak Walton as expressed in his *Compleat Angler*. He wanted to divert the minds and hearts of his listeners away from the cares of the war torn world to the peaceful pursuit of trout fishing, a Pursuit unequalled in affording an opportunity for contemplation and communing with God's creatures. "I sing the praises of the soothing environment of the sweet water

fishing for trout with wet or dry fly....." He noted that Dr. Johnson had described bait fishing as no more than a stick with a string with a worm on one end and a fool on the other. He quoted many well known physicians and surgeons who shared his enthusiasm for fishing. He pointed out that the *Compleat Angler* was not a great piece of literature.... yet the *Angler's* pleasant pages are still a solace for the cares of too practical lives; it has soothed and cheered generations of readers of English letters... Walton was not a profound thinker nor very learned or well informed in the natural sciences, but he loved God's creatures and the environment... Out of great simplicity of mind and heart, he wrote with a depth of feeling often with the light touch of the poet Since the appearance of the *Compleat Angler* in 1653, it has been reprinted 283 times."

With sparkling eyes, Jim Waring entertained his colleagues, unaware that the pleasures he was prescribing would soon become a rare event, perhaps an impossible dream for many of his listeners. He returned home to the School of Medicine to begin a very difficult four years of being the primary teacher of medicine in a school where over half the faculty had gone off to the war. And the teaching was for twelve months out of the year, no summer recess for vacation trips to a favorite fishing stream. Nevertheless, Jim Waring's love of medicine and his wry sense of humor sustained him through those difficult four years. He was the ultimate clinician and teacher.

There was another physician struggling with wartime shortages. Down at the State Office Building in the Board of Health offices, Dr. Roy L. Cleere was fighting a different sort of battle to preserve the health of the citizens of Colorado. No, he was not a clinician, but his work was an enormous importance. At times he must have thought it was a losing battle. In a paper entitled the "Health Problems in Colorado," presented at the annual meeting of the Colorado Public Health Association on June 8, 1944, he began with "...the sense of well being afforded by the salubrious climate of Colorado lulls its citizens into a false sense of health security. No doubt many persons have been benefited by the climate... but there are some rugged individualists who believe that the water supply of a town derived from a "pure" mountain stream should not be contaminated with chlorine." Quoting from an 1893 report of the State Board of Health, "In the light of the sanitary history of Denver and each camp in Colorado with the scores of deaths from preventable diseases -- typhoid, diphtheria and small pox -- it is clear enough that Colorado's climate has strict and narrow limitations in its beneficial influence..."

In support of this "blasphemy", Dr. Cleere presented some grim and convincing data:

Colorado's overall death rate was higher than the national average. In 13 of the 20 leading causes of death, Colorado's death rate was significantly higher. Tuberculosis, though reduced from the number one killer to number six, was still

higher than the national average. Small pox and diphtheria (wholly preventable) continued to cause too many needless deaths. Even pneumonia with better therapy available was causing more deaths than the national average. In a very depressing report, he listed the state's failures because of the war manpower shortage, but a more serious problem was the laws governing the Board of Health, laws which had not been changed since their adoption in 1876. He pointed out that these laws required that he, as secretary to the Board of Health was to punish all people found spitting in public (which was prohibited by law) and to police interstate carriers to prevent the introduction of Asiatic cholera into the state. There was no State law requiring pasteurization of milk. Indeed, milk production and the associated sanitation came under the jurisdiction of the state Department of Agriculture and not the Health Department. So the incidence of milk-borne disease such as brucellosis was higher in Colorado. Antiquated laws and a somnolent legislature were a source of great frustration to this young, idealistic physician.

Most dramatic in Dr. Cleere's report was the section on rheumatic fever, a disease that killed more children between the ages of 5 and 14 than diphtheria, poliomyelitis, scarlet fever, measles, meningococcal meningitis and whooping cough combined. An unusually virulent strain of hemolytic streptococcus had invaded Colorado causing an epidemic in Colorado and the Rocky Mountain states. Colorado was second in the number of deaths due to rheumatic heart disease. The military posts in Colorado reported a higher incidence of rheumatic fever in servicemen than any other state. Pediatricians and other physicians in civilian practice, already burdened by wartime shortages, were stretched to the limit caring for these disparately ill children. Waring and his pediatric colleagues at Colorado General Hospital noticed the increasing incidence and severity of the disease with great concern.

Down at Children's Hospital, pediatricians like W. W. Barber and Emanuel Friedman were doing their best to help these children. Friedman was one of a kind. He was a small, quiet, gentle man who seldom refused a request for a home visit. He would leave his office at 326 Republic Building with a list of addresses he was to visit before making his evening rounds at Children's Hospital. Dressed in the same dark suit and a white shirt with a high collar and shoes that looked like goulashes, he would knock on the door of the first home on his list. A worried mother would greet him at the door. In the child's room, he would look down on his little patient who stared up at him, short of breath



Dr. Roy L. Cleere

and hoping this kind man could make him feel better. This little patient had been acutely ill 4 months earlier with a severe streptococcal pharyngitis which was followed in two weeks with painful, migrating inflamed joints. It was then that Dr. Friedman could have helped more if he had been called earlier. Those painful joints could be dramatically relieved with aspirin, and the damage to the heart might have been mitigated with rest and care. But now as Dr. Friedman saw this pale, dyspneic child with precordium pulsating and listened to

the ominous, low pitched, pre-systolic murmur, he knew the mitral stenosis was worsening, the left ventricle was enlarging and the lungs were edematous. How frustrating it was to be of such little aid. It would be several years before another dedicated physician, Henry Swan, would come back from the war and develop open heart surgery that would enable him to repair the damage caused by the rheumatic fever. But Friedman continued with his home visits until he finally arrived at the hospital some times as late as 11:00 p.m. There he quietly visited his patients, meticulously recording his findings and wrote in a tiny precise hand, the orders for each patient. Finally, he arrived home at midnight where his wife served him his evening meal. This man had no time for Dr. Waring's prescription for fishing. He exemplified the physicians during those war years who believed that patient care started with caring for the patient. Almost all physicians were over-worked during the war. Admirable as Dr. Friedman was, his example could not be reasonably followed by most physicians. Though all these clinicians worked endlessly to help these youngsters, this may have been a time when an ounce of prevention was worth more than a pound of cure.

In addition to the large number who died from rheumatic heart disease, there were the uncounted numbers who were permanently disabled by the disease. As the state's public health officer, Roy Cleere developed a plan for early diagnosis and treatment. Early treatment of the streptococcal infection and the subsequent rheumatic fever might result in fewer deaths and less disability. So he developed a plan using the clinics at Colorado General and Denver General Hospitals, the Ave Maria Clinic and other private hospitals that may have wished to participate. He proposed follow up care using nurses from the Health Department and the Visiting Nurse Association and social workers from the participating hospitals. Money would come from

the community "War Chest" (now called United Way), from the Children's Bureau of the Federal government and the state Health Department. Hoping to gain the support and cooperation of the Colorado Medical Society, he presented the plan to the Public Policy Committee of the Society. The committee members, John S. Bouslog, George P. Lingenfelter and Bradford Murphey met with Dr. Cleere and members of the Board of Health on May 26, 1944. It is not known if Dr. Cleere knew what he was facing. He had been a member of the CMS for several years. He was a young man, idealistic, trying to do his job of protecting the health of Colorado citizens. He should have known that Bouslog, Lingenfelter and Murphey were the stalwart conservatives of the CMS. This triumvirate spoke out in loud, eloquent and sometimes strident speeches about the dangers of socialized medicine and the infamous Wagner-Murray-Dingell Bill. They were suspicious of any effort by a government bureaucracy to enter into the practice of medicine. They met with Dr. Cleere, listened to his presentation, raised numerous questions and then rejected his plan in its entirety. They promised to submit an alternative plan within the week. Their plan insisted that only private hospitals and physicians in private practice be used and the bureaucrats in the Children's Bureau be forbidden to interfere in any way other than providing funds. Dr. Cleere left the meeting somewhat disheartened, a sadder but wiser man. Nothing else about the rheumatic fever prevention and treatment program appears in the pages of the Rocky Mountain Medical Journal. Probably Dr. Cleere did his best without the official collaboration of the Colorado Medical Society.

One year later, rheumatic fever was still a very serious problem. The University of Colorado School of

Medicine offered a three day "refresher course" on the diagnosis and treatment of rheumatic fever on June 4, 5 and 6, 1945. Keynote speaker and guest consultant was Dr. T. Duckett Jones of Boston. Faculty for the course included Drs. James J. Waring, A. G. Wedum, H. D. Palmer, Karl Neuberger, Abe Ravin, Ward Darley and Atha Thomas, all of whom spoke at the Clinical Amphitheater at Colorado General Hospital. At Children's Hospital, Drs Paul H. Rhodes, E. R. Mugrage and Douglas Deeds demonstrated cases and the use of the laboratory and the electrocardiogram. Chorea or St. Vitus Dance was discussed by Dr. John Lyon. The course cost \$20 which included lunch for the three days. By this time, we knew the importance of aggressively treating streptococcal infections with sulfadiazine or penicillin if that were available. It was even suggested that 0.5 gram of sulfadiazine daily was a safe and effective way to prevent reoccurrence of the infection and the subsequent rheumatic fever. As penicillin became more available, it became the drug of choice, and the incidence of the disease declined. Today you seldom hear of it.

Venereal disease is another area where the interface between clinical medicine and public health had a dramatic impact. Several years before the beginning of the war, Thomas Parran, Surgeon General of the U. S. Public Health Service, began a campaign to eradicate syphilis and gonorrhea through public education, aggressive case finding and treatment. Case workers were trained to persuade patients to reveal their sexual contacts, then find these contacts, test them for presence of the disease and persuade them to accept treatment. Find them and treat them. With the advent of penicillin, this became a very effective program. For example, Ward L. Chadwick, M.D. Surgeon (R) with the U.S.P.H.S. and director of the Division of Venereal Disease Control of the State Health Department, published an article in the November, 1943 issue of the Rocky Mountain Medical Journal in which

he described a four hour office treatment of gonorrhea. He gave the patient 200,000 units of penicillin divided into 3 doses at two hour intervals. He reported a 95% cure rate. Here was the state and federal governments intruding into the area of clinical medicine. Was this a subtle beginning of socialized medicine. Some say Surgeon General Tom Parran's venereal disease control program was a real success. The incidence of sexually transmitted disease showed a dramatic and significant reduction.

Bradford Murphey, John Bouslog and George Lingenfelter and their conservative colleagues were earnestly concerned about the deleterious effects of governmental intrusion into the practice of medicine. But Roy Cleere, Lloyd Florio and other liberal physicians were just as earnestly concerned about the prevention of disease and the preservation of health. It was a conflict that had started several years before and would continue for the rest of the 20th century. Medicare is now an accepted part of medicine. HMOs and Managed Care have also intruded into the practice of medicine.

If Dr. Murphey came back from his grave, he might well say, "I told you so".

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Medicine and the Information Age

Jeffrey S. Rose, MD

Director of Clinical Information Systems, Kaiser Permanente

The Diagnosis

In 1993 Dr. Melvin Konner colorfully described the American healthcare dilemma as "Medicine at the Crossroads." Since then, doctors, patients, clinicians, consumers and medical enterprises have stepped up to tackle our healthcare system problems and control the medical expenditures that comprise 15% of our GNP (nearly a trillion dollars a year). Unfortunately, they have only compounded the problem because the real issue is not economic, political, academic in nature—it's fundamentally a medical conundrum.

The attendant intellectual, emotional and cultural factors that entangle our healthcare dilemma would take volumes to completely unravel (many are tackled in my book, *Medicine and the Information Age*). But, at its unpalatable root, one discovers the core problem is the delivery of medical care in an atmosphere of insufficient information. To be alarmingly blunt, clinicians and patients have accepted, indeed embraced, diagnostic investigations and treatments for which there is surprisingly sparse objective rationale—medical folklore abounds, and the use of unproven expensive technology in healthcare is the major driver of increasing costs.

Consider these facts:

Eighty percent of the healthcare decisions that doctors make are not grounded on any scientific evidence of effectiveness, yet these decisions are responsible for fully two-thirds of the unfathomable "potentially controllable" costs of care in this country.

The vast majority of ill patients being seen would recover without any medical intervention whatsoever.

Fourteen percent of patients in hospitals are actually injured during their stay. Prescribed unproved medications actually diminish the health of patients each year (the adverse reactions to medications rank among the top 10 causes of hospitalization and are responsible for more patient deaths each year than breast cancer).

It almost makes you believe pediatrician Robert Mendelsohn's assertion that, "More than 90% of modern medicine could disappear from the face of the earth—doctors, hospitals, drugs, equipment—and the effect would be immediate and beneficial."

One could go on and on about all this, but the simple fact is that for very many diseases and complaints, we don't know what the best methods of diagnosis and treatment are.

Science just doesn't have the answers. Clinicians, despite enormous knowledge and considerable education, don't know and can't possibly remain current with appropriate "best medical practices." This lead Melvin Konner to accurately observe that:

"Few patients understand how many decisions are a toss up, and

how bleak and forbidding the landscape of disease can look even to those who know more about it than anyone else in the world. Doctors, scientists, and journalists have given us all, including themselves, such a hard sell about advances in medicine that only the most sophisticated visit a physician any more without overestimating what the physician can do."

The Disease

Medicine today is practiced in a milieu of relative ignorance; a condition I call "informaciation," which consists of three related disorders.

1. Inadequate patient information when clinical decisions are made. Patients often require services at multiple physical sites and in various settings, unfortunately, essential facts are unavailable to caregivers at least one-third of the time when critical decisions must be made. This is true in emergency departments nearly 100% of the time, when prior health information is most important. If you have the misfortune to appear in an emergency room, the likelihood is extremely high that the institution you are in could access your credit report, your bank balances, your travel history, and a host of other data; but they will not be able to ascertain your health status, your medications, your allergies, your past medical problems, or your ongoing conditions. The ability to access vital health information has faltered as long term doctor-patient relationships have been disrupted by insurers and employers attempting to control costs.

2. Inadequate evidence to guide diagnostic and treatment choices and to maximize effectiveness and value. When medical records are available, they are routinely illegible, incomplete and disorganized, which makes deriving good information from them difficult and time consuming. Even more disturbing is the fact that even if medical charts could suddenly become complete, legible, and uniformly available, a very serious problem remains because there is precious little consistency in the use of clinical terms and concepts between doctors. Failure to agree upon uniform language and descriptions in medicine has severely hampered our ability to apply science to treatment and makes evaluation of data across a healthcare system nearly impossible.

3. Data toxicity—an overload of redundant, inaccurate, uninformative, or confusing facts, leading to incorrect conclusions.

Data toxicity exists in at least two forms. The first is the result of ambiguous, biased or incorrect information that based on "billing codes" (those rigid identifiers care providers must submit in order to be paid). These codes fall far short of clinical accuracy and are often contaminated by "code creep" and "unbundling" (techniques of maximizing reimbursement). The second form of paradoxical data pollution results when data about a patient or a condition, often discovered accidentally, are nothing more than red herrings—noise or diversions from relevant issues. When something is detected that isn't significant, or when the absence of an expected finding sends the doctor careening down the wrong path, further expensive test ordering is generally needed to sort things out—the financial and emotional costs of working up these irrelevant finding are not trivial. An example of this phenomenon was publicized in April when the detrimental effects of mass mammography screening were acknowledged due to discovery of "nothings" (or ditzles as we call them) that mandated further work-up and resulted in enormous anxiety, pain, and unnecessary surgical procedures.

The Cure

Clinical information systems represent the only realistic method physicians have to treat informaciation. Such systems can allow full access to patient information, mitigate misuse of tests, balance arrogant biases inflicted during training, validate or disprove "community standards," and support clinicians and patients with "evidence" on which to base their decisions. The cure for the healthcare crisis is very apparent: apply any measures possible to improve the quality of information available to caregivers at the time of treatment, and to improve the basis upon which clinical decisions are made. Only when this goal has been accomplished, through use of information technology, terminology standards and improved communications will clinicians have the time and capacity to focus on the important aspects of relationship in healing. Cost cutting, legislation, mandates for coverage, insurance reorganizations or political debate cannot solve this conundrum.

The barriers to collecting, evaluating and acting upon good information are profuse—particularly among doctors (these are reviewed in *Medicine and the Information Age*). If the information age doesn't revolutionize medicine as it has almost every other industry, there is no question that healthcare as it exists today will not survive. In my professional capacity I interact with many clinicians in all sorts of organizations, and none of them are happy with the status quo. Some deny that there is a problem, others are angry and lash out at lawmakers and institutions, still others bargain to protect themselves from having to change their habits and methods. Many are depressed, giving up, leaving practice and applying for disability benefits in record numbers. Happily, there are those who have accepted the need to incorporate new technology into their practices. They have embraced the need to practice based on standards and guidelines; they have acknowledged their human fallibility in the face of overwhelming evidence to support that claim; they have become learners again—innovators in a new world. Denial, anger, bargaining,

depression and acceptance; healthcare is manifesting Kubler-Ross' five stages of dying.

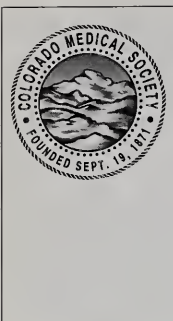
So what will you see in the future, here, in Colorado, and across the nation if we are to survive?

You will see computers in your doctor's offices and exam rooms. You will no longer have to bring a paper bag full of empty prescription bottles to your doctor as suggestive proof of what you are taking. Emergency rooms and geographically dispersed caregivers will know your allergies and medical history at the click of a mouse, and will engage you in combined patient/doctor decision making based on facts, evidence and probabilities.

One example of such an effort is the system the Rocky Mountain Division of Kaiser Permanente developed in partnership with IBM. The clinical information system developed there makes nearly a million medical records available on a secure network to some 2,500 authorized caregivers on 3,200 clinical workstations throughout the Denver metropolitan area. The system is based on a standard (or controlled) medical vocabulary which assures data comparability for outcome studies and a base for clinical decision support, alerts and reminders in the future, and it makes patient information available at all locations instantly, and even simultaneously, within the system. Other healthcare enterprises are gearing up in the same way, with vendor product purchases or development efforts in the hope of improving the quality of clinical decision making and enhancing service to and effectiveness with patients.

Elimination of overhead and profits across the healthcare spectrum will not stem the intolerable rises in medical inflation, nor improve the effectiveness and safety of clinical interventions. In fact, such draconian measures may degrade the quality of healthcare.

In this new (to medicine) world, clinicians, not computers, will still care for you—but they will do it as a team. The access to patient information, to evidence based guidelines for care, and reminders about procedure appropriateness and safe prescribing will allow clinicians to improve quality and gain control of the costs of care. This is the only acceptable solution to the current problems.



LETTERS TO THE EDITOR (AND OTHERS)

Dear Bill:

I enjoyed your September "Ruminations,"* first because they reminded me of myself volunteering for the Air Force at nineteen, and the blanched face of my mother when I came home and told her. I was rejected because of a few high blood pressure readings.

Then I remembered my uncle, Dr. Jerome Head, a college teacher of English when he volunteered in World War One. He told his distressed mother "I'm healthy, and not married. Who could better go?" He taught artillery until he convinced the Army to send him overseas.

During the voyage the Armistice was signed, so the greatest danger he and his friends faced was breaking into the bricked-up chambers of French vineyards to find the Champagne hidden from the Germans. Years later, as surgeon and historian, he saw another war wasting our young men. Though I don't believe he actually volunteered, he was absolutely serious in suggesting that America call up its older men before taking all our young men from their work, their colleges and families. He said he could see, and press a trigger, as well as anyone, maybe better.

So your suggestion is more practical than facetious. I suppose it will never fly.

Best wishes
Thomas Head Coleman, MD
Denver

Dear Bill:

What a wonderful tongue-in-cheek article* in the Sept. *Colorado Medicine* "Ruminations." I'm still chuckling.

Joseph S. Pollard, MD
Colorado Springs, CO

Bill Pierson:

I was just looking at the (November) *Colorado Medicine* and was reading your column, *Ruminations*. Great column! I think you're right: "Under Siege" is probably an apt way to describe what's going on in this country, with all the special interest groups and the lack of clarity of who we are and what we want to be.

Fascinating comments and I enjoyed the column.

Paul Schauer
(Colorado State Representative)
Arapahoe County, CO

*The article referred to had to do with reversing the spectrum of aging and a new role for senior citizens. The article's subject had nothing to do with John Glenn going into space; it was just a fortunate coincidence that he blasted off at the time the article was published.

Editor.

November 4, 1998

Ms. Sandra Maloney, Executive Director

Gary D. VanderArk, M.D.
Past-President, Colorado Medical Society

and the officers and directors of CMS

Dear Sandi, Gary and all the rest of you:

It's been 45 days or so since you made a fuss over me, and I'm still basking in the glow of it. The gorgeous clock, complete with engraved sentiments, is on prominent display in our reception area.

It is a great time to be in the health care delivery business, if you like challenges, and if change doesn't get you down. We here at the firm look forward to more change and more challenges with you. Nothing could be more energizing and rewarding.

Thanks, again, for your trust and support, and for the honor you so graciously gave us*.

R. Montgomery
Montgomery Little & McGrew
Attorneys at Law

* Mr. Montgomery was presented the plaque at the Annual Meeting of the CMS House of Delegates on September 12, 1998. He was recognized for his dedicated efforts and counsel on behalf of the Society over the past decade.

11/11/98 5:30 PM

Dear Dr. Shanks:

THANKS for being our CMS President (better than that draft-dodging wimp who infests the White House in DC).

Patients are what we are about. I never ever again want to write an e-mail that concludes "All 5 children died... Hope this helps".

I would have gone to the Gulf as an Air Force Reserve Flight Surgeon from Peterson AFB in Colorado Springs (and Noriega's guys tried to kill me and my troops, but that's another story -- they didn't succeed).

If you want to start wars, just perhaps you should have done some pushups in Leesville, LA.

NOBODY who isn't a physician knows about treating the sick and hurt. (You ain't had your hands in somebody's chest and blood dripping off your shoes, then you ain't been there.) I would educate them if possible.

My father served as a corporal with General "Blackjack" Pershing in WWI in the trenches of France. In his memory, what can I do to serve our patients?

Yours truly,
Alan H. Hall, MD, FACEP
Major, US Air Force Reserve
Medical Corps, Hon. Ret.

Date: 11/23/98 11:13 AM

I have just read that another physician's organization is suing to have the facts of the Sunbeam case made public. I am concerned that the AMA is trying to cover up something that they should make public. I also don't understand why such a large amount was paid. I think the inference that Drs would recommend against Sunbeam products should have sufficed.

Again with all the secrecy I am suspicious that "something is rotten in Denmark".

Paul B. Jones MD

House Bill 1062 - Update

In October, the Division of Worker's Compensation attempted to explain the Changes that House Bill 1062 mandated on the Workers' compensation program. Primarily, those changes were to ensure the swift filing and processing of claims. Objections might be made about various legal issues or the determination of maximum medical improvement or the final impairment rating.

Since that time, physicians are beginning to call state offices asking questions about the new processes as they find themselves besieged with questions and requests by the public. Most questions arise concerning who can conduct Independent Medical Examinations (IME). Prior to HB 1062, only physicians who had agreed with the state to conduct IMEs on the state's terms could conduct a Division IME (called Section 107 IMEs). The bill changed this.

Under the new provisions of the law, the claimant and the carrier must try to agree on the selection of a physician to conduct a Section 107 IME when one is indicated. Although that physician must still be Level II accredited (by the Division of Workers' Compensation), he/she need not be a member of the IME panel administered by the state in order to participate in these cases. These types of reviews are being referred to as "non-state administered Section 107.2 IMEs."

What does this mean to the physician? It means that claimants and/or carriers may be calling his office directly to set up the IME appointment, and may be communicating directly as well about additional fees for record review, diagnostics, and missed appointments/penalties etc. In addition, at the completion of the report, the physician will be sending the written report to the requesting party, not the state, and answering whatever questions are raised to that party directly. The Division will not be reviewing the physician's report for completeness or compliance with the rules.

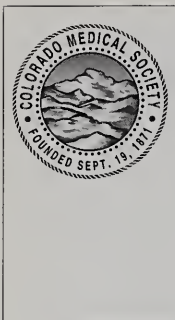
How can this type of procedure be billed? According to the new rules the physician taking on these IMEs must bill pursuant to the "referral" fee set forth in Division Rules and Regulations, Rule XVIII, section F.6.d.2(b) unless other-

wise ordered by the Director of the Division or an administrative law judge. The fee works out to be approximately \$450.00, a fee equal to that of IME panel physicians.

How will a physician know what type of IME he is being asked to perform? This is one of the most difficult aspects of the new legislation. Under prior statutory authority, physicians have always been able to perform Section 502 IMEs. These are informally called expert opinion IMEs and physicians historically charged what the market will bear for these exams. These opinions do not have the force and effect of law, as do the Section 107 IME opinions. The simplest way to distinguish the new Section 107.2 IMEs from one another would be to ask two questions - first, is the IME to resolve a dispute over MMI and/or impairment; and second, ask the requesting party whether or not the parties have voluntarily agreed upon the physician, or whether the Division has selected the physician for the review. In most cases, it does not matter how the physician is selected, since his obligation as an independent reviewer is the same. However, office confusion may occur about the differences in the way of parties may communicate pursuant to the new legislation.

Is there any other impact from the new legislation on the IME physician? In Division administered IMEs the staff reviews the physician reports before determining that they are complete as sending them to all parties. This review is intended to catch any oversights or mistakes in process that have occurred during the IME process. Thus, when a report is deemed final, the parties can focus any disagreements on the substance of the review, not procedural errors. In non-Division administered IMEs, this review, will be omitted. Physicians may wish to implement some sort of office review that would fulfill the same function. This should help eliminate unnecessary litigation and ensure that the physician has regulatory support (Guideline compliance) in his decisions.

If you have questions or wish for further information, please contact the IME unit at (303) 575-8840.



THE LOBBY



*Christopher Unrein, DO
Chairman, CMS Council on Legislation*

Possible 1999 Legislation

As this issue of Colorado Medicine goes to print, the Council on Legislation is aware of 22 bills, which are being considered for introduction during the 1999 session of the Colorado Legislature. A listing of those bills and a brief description of each follows. This list will be continually updated on the CMS Home Page "For Physicians Only" section.

4 Medically Indigent Bills

Bill 1- Medicaid Asset Test- Creates a universal test to determine eligibility for both Medicaid and welfare assistance.

Bill 2 – Additional Funds for Children's Basic Health Plan- Requires that additional funds from the state's general fund be appropriated to the Children's Basic Health Plan.

Bill 3 – 12 month Eligibility for Medicaid- Guarantees Medicaid eligibility for 12 months.

Bill 4 – Prenatal Care for Undocumented Aliens – Requires the state to provide prenatal care for undocumented aliens.

1 Medically Indigent Resolution

Joint Resolution – Higher Reimbursements to Colorado Indigent Care Program (CICP) Providers – This resolution urges increasing reimbursement rates for CICP providers.

Naturopaths

Speaker of the House Russell George will be carrying a bill to regulate naturopaths. At this time it is unclear if this will be a title protection bill or a licensure bill with a defined scope of practice. Title protection would prohibit persons from calling themselves a "Naturopath" unless the individual has met the criteria outlined in the bill (i.e. graduation from a recognized program.) Licensure could include a defined scope of practice allowing them to diagnose, provide nutritional advice, mental health counseling, spinal manipulation, acupuncture, prescriptive authority, obstetrics and minor surgery.

Exempting Shriner's Clinics from Telemedicine Laws

A bill was passed in the last session that requires any physician who provides care to a patient in Colorado to have a Colorado medical license. The Shriner's Hospital wishes to exempt physicians who provide medical care in Shriner's- sponsored clinics from this licensure requirement.

Physician Assisted Suicide

CMS anticipates that a bill will be introduced declaring "physician assisted suicide" to be manslaughter.

Health Care Task Force

In May 1998, Governor Romer vetoed a bill creating a "Health Care Task Force." The same bill is expected to be introduced again in the 1999 legislative session with modification to the membership of the Task Force. The purpose of the Task

Force is to develop and provide expertise in the health care arena for the legislature.

Chiropractic Prescriptive Authority

A small group of chiropractors are expected to again seek prescriptive authority in this upcoming session. The CMS and the Colorado Chiropractic Association (CCA) opposed a similar proposal in 1998.

Prescriptive Authority for Pharmacists

A similar bill to the 1998 version is expected in 1999. The 1998 version would have granted pharmacists the ability to initiate, modify or discontinue prescriptions, do history and physicals on patients and order and analyze laboratory tests.

Termination without Cause

Per CMS RES-19-P (AM '98), CMS will pursue introduction of a bill to prevent arbitrary and capricious terminations without cause from managed care panels.

Elimination of the PCP Program for Medicaid

A rumor is circulating that a managed care organization will seek to eliminate the PCP (Primary Care Provider) Program from the definitions of "managed care" in a mandate that requires 75% of Medicaid recipients be enrolled in managed care.

Independent Review for Health Care Benefit Denials

This bill, if introduced, will require workers' compensation and auto no-fault patients have access to an independent external review

panel to dispute benefit denials.

Enterprise Liability

A bill is expected which will allow patients to sue their managed care plan for harm caused by the denial or delay of health care benefits.

Notification of Credentials

The Colorado Nurses Association (CAN) may introduce a bill that will require health care personnel to wear identification displaying their credentials in settings other than individual medical offices.

Mandatory TMJ Coverage

The Colorado Dental Association will seek legislation requiring the coverage of temporomandibular joint dysfunction when a plan covers the care of other joints in the human body.

Primary Offense for Seat Belts

A bill declaring the failure to wear a seatbelt a "primary offense" will be introduced. This will allow law enforcement to issue citations for failure to wear a seatbelt without having another reason to pull a car over.

External Reviews

This bill will establish the right to an external review of health care benefit denials for patients of managed care.

Immunity from Liability for Charitable Care by Retired Physicians

This bill will provide immunity to retired physicians for the delivery of uncompensated, charitable health care services.

Defining "Medical Necessity" as the Practice of Medicine

At least one legislator has expressed interest in introducing a bill to define the determination of "medical necessity" as part of the practice of medicine, thereby requiring a physician make such determinations.

NOTE: Lorraine L. Koehn, Director of CMS Government Relations, contributed to this assessment report.



CMS 1999 Board Meeting Schedule

January 6-9	State Health Legislation Meeting (Tucson, AZ)	
January 20	AMA Delegation Debriefing	6:30 pm
January 22	Finance Committee	1:00 pm
	Board of Directors	2:00 pm
February 17	Executive Committee	5:00 pm
February 26	Medically Underserved Conference (Terrace Gardens at Dove Valley)	
February 27	Interim Meeting Educational Session (Terrace Gardens at Dove Valley)	
March 20-23	AMA Leadership Conference (Washington, DC)	
March 26	Finance Committee	1:00 pm
	Board of Directors	2:00 pm
April 7	AMA Delegation Caucus	6:30 pm
April 21	Executive Committee	5:00 pm
May 14	Finance Committee (Sonnenalp, Vail)	1:00 pm
	Board of Directors (Sonnenalp, Vail)	2:00 pm
May 15-16	CMS Leadership Conference (Sonnenalp, Vail)	
June 9	AMA Delegation	6:30 pm
June 20-24	AMA Annual Meeting	
June 30	Executive/Finance Committee	1:00 pm
	Budget Review	
July 21	AMA Delegation Debriefing	6:30 pm
July 30	Finance Committee	1:00 pm
	Board of Directors	2:00 pm
August 5-8	AAMSE Annual Conference (NY Hilton)	
August 18	Executive Committee	5:00 pm
September 16	Finance Committee (Hyatt Regency, Beaver Creek)	1:00 pm
	Board of Directors (Hyatt Regency, Beaver Creek)	2:00 pm
September 17-19	CMS Annual Meeting (Hyatt Regency, Beaver Creek)	
October 13	AMA Delegation	6:30 pm
October 20	Executive Committee	5:00 pm
November 19	Finance Committee	1:00 pm
	Board of Directors	2:00 pm
December 5-8	AMA IM Meeting (San Diego Marriott)	



edicare Update

Marilyn Rissmiller

Program Manager, Division of Health Care Financing

January 1st will bring coding changes for Medicare (and most other insurance carriers). Your billings will need to be submitted using the new and revised codes found in the 1999 ICD-9-CM and the CPT '99. It is important that you or your staff compare the diagnosis and procedure codes you use frequently to those found in the 1999 CPT and ICD-9, to ensure that your billings are not delayed or denied due to incorrect codes. In addition, be sure to review the Medicare HCPCS changes that were published in the December 1998 *Medicare B News* bulletin. Following is a highlight of some of the things to look for.

ICD-9 Changes – Effective 1/1/99

The following codes are **no longer valid** and have been replaced by those in italics:

- 482.4 Pneumonia due to *Staphylococcus* – **now requires a fifth digit**
 - 482.40 *Pneumonia due to Staphylococcus, unspecified*
 - 482.41 *Pneumonia due to Staphylococcus aureus*
 - 482.49 *Other Staphylococcus pneumonia*
- 519.0 Tracheostomy complication – **now requires a fifth digit**
 - 519.00 *Unspecified tracheostomy complication*
 - 519.01 *Infection of tracheostomy*
 - 519.02 *Mechanical complication of tracheostomy*
 - 519.09 *Other tracheostomy complication*
- 564.8 Other specified functional disorders of intestine – **now requires a fifth digit**
 - 564.81 *Neurogenic bowel*
 - 564.89 *Other functional disorders of intestine*
- 763.8 Other specific complications of labor and delivery affecting fetus and newborn – **now requires a fifth digit**
 - 763.81 *Abnormality in fetal heart rate or rhythm before the onset of labor*
 - 763.82 *Abnormality in fetal heart rate or rhythm during labor*
 - 763.83 *Abnormality in fetal heart rate or rhythm, unspecified as to time of onset*
 - 763.89 *Other specified complications of labor and delivery affecting fetus and newborn*

- 965.6 Poisoning by antirheumatics (antiphlogistics) – **now requires a fifth digit**
 - 965.61 *Poisoning by propionic acid derivatives*
 - 965.69 *Poisoning by other antirheumatics*
- V02.5 Other specified bacterial diseases – **now requires a fifth digit**
 - V02.51 *Group B streptococcus*
 - V02.52 *other streptococcus*
 - V02.59 *other specified bacterial diseases*
- V13.6 Personal history of congenital malformations – **now requires a fifth digit**
 - V13.61 *Personal history hypospadias*
 - V13.69 *Personal history other congenital malformation*
- V16.5 Family history of malignant neoplasm of urinary organ – **now requires a fifth digit**
 - V16.51 *Family history of malignant neoplasm of kidney*
 - V16.59 *Family history of malignant neoplasm of other urinary organs*
- V18.6 Family history of kidney diseases – **now requires a fifth digit**
 - V18.61 *Family history of polycystic kidney*
 - V18.69 *Family history of other kidney diseases*
- V23.8 Supervision of other high-risk pregnancy – **now requires a fifth digit**
 - V23.81 *...elderly primigravida*
 - V23.82 *...elderly multigravida*
 - V23.83 *...young primigravida*
 - V23.84 *...young multigravida*
 - V23.89 *...other high-risk pregnancy*
- V44.5 Cystostomy status – **now requires a fifth digit**
 - V44.50 *Unspecified cystostomy status*
 - V44.51 *Cutaneous-vesicostomy status*
 - V44.52 *Appendico-vesicostomy status*
 - V44.59 *Other cystostomy status*

CPT '99 Changes – Medicare allows a 90 day grace period

There are numerous changes in the new CPT, many of them directed at clarifying when a code is an "add-on" – that is, it can be billed in addition to another. The majority of these explanatory changes are in the Integumentary, Musculoskeletal, Nervous and Eye sections of the CPT. There are also a number of new pathology and immunization/vaccination codes.

1999 HCPCS Changes - Medicare allows a 90 day grace period

Following are some of the HCPCS codes which are no longer valid and their replacements:

- G0133 Ultra-sound bone mineral study, one or more sites...- **replaced by new CPT code 76977** - *Ultrasound bone density measurement and interpretation, peripheral site(s), any method*
- P9610 Catheterization for collection of specimen...home bound, nursing home or SNF - **replaced by new HCPCS code P9612**
- Q0162 Catheterization for collection of specimen...all places of service - **replaced by new HCPCS code P9612** - *Catheterization for collection of specimen, single patient, all places of service*

The following two new HCPCS codes are to be **used in place of CPT code 76070**:

- G0131 Computerized Tomography bone mineral density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)
- G0132 Computerized Tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

Medicare Payment Changes

- Beginning with dates of service 1/1/99 and after the conversion factor for medical and surgical services

will be \$34.7315. The anesthesia conversion factor will be \$17.24. Although the medical/surgical conversion factor for 1999 is almost \$2 less than 1998, because of changes to the Practice Expense RVUs and the Medicare Economic Index, the overall payment result is actually an increase of 2.3% (more mathematical magic).

- The Practice Expense component (office overhead) of the RBRVS payment system has been recalculated using additional data from the AMA and specialty groups. The changes in the Practice Expense units are intended to redistribute additional payment amounts to office-based services, particularly E & M visits. The revised Practice Expense RVUs will be phased in over a four-year period beginning in 1999.
- The 1999 Medicare Disclosure Report (fee schedule) will look different. There will no longer be an "across the board" site of service differential of 50% of the practice expense for services provided in the other than the office location. Beginning in 1999, the differentials will be built into the practice expense value by CPT code.

If you have any questions on the Medicare changes, you can contact Marilyn Rissmiller in the CMS Health Care Financing Department at (303) 779-5455 or 1-800-654-5653, ext. 2428.

Who's

WATCHING OUT For You?

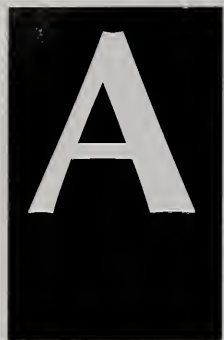
From providers to community leaders, researchers to educators, and government officials to citizens, the National Rural Health Association's members seek to improve the health care of rural Americans through advocacy, communications, education and research.

The National Rural Health Association and its members work to overcome rural health care challenges. They focus on reforming and strengthening health care to meet the needs of rural areas. While government funding continues to dwindle, this multi-disciplinary group of health professionals and leaders finds innovative solutions to complex dilemmas.

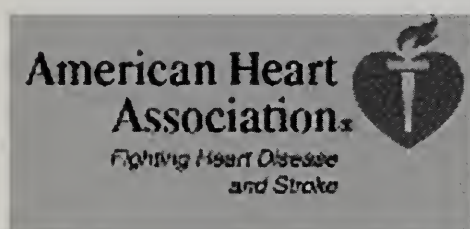


NATIONAL RURAL HEALTH ASSOCIATION — *Caring for the Country*

For more information, contact the NRHA,
One West Armour Boulevard, Suite 301, Kansas City, MO 64111;
816-756-3140; fax 816-756-3144.



American Heart Association Task Force



*Editor's note: This article was contributed to **Colorado Medicine** by the Colorado Chapter of the American Heart Association*

The American Heart Association recently invited a group of top Colorado policymakers and public health advocates "to give us advice on the American Heart Association's legislative priorities locally and nationally." The group will serve as the AHA's first Public Affairs Task

Force, and will include First Lady Bea Romer, Wilma Webb, Former Governor Dick Lamm and State Representative Martha Kreutz.

"Public affairs is a whole new focus for the AHA in Colorado," announced David Badesh, MD, AHA Denver Board president and chair of the new task force.

"The AHA needs to have a major voice and let our elected leaders know we care, especially about the war against tobacco. As the father of two children, I am especially motivated to work on keeping tobacco away from Colorado children." Dr. Badesh led last year's campaign to pass the tobacco-free schools law in Colorado.

The new task force will guide the AHA on the following issues and legislation in 1998-99:

- keeping tobacco away from children
- the tobacco settlement in Colorado
- expanding emergency medical care
- clear indoor air supporting regular physical education classes in schools

Members of AHA's new task force also received a special invitation from Attorney General Gale Norton, guest speaker who presented an update on the tobacco settlement in Colorado.

"We want to hear from public health representatives. Our office is putting together a task force to take input on tobacco related issues, and we invite you to join."

The AHA's task force and public advocacy efforts will be led by Michael Huttner, recently hired as

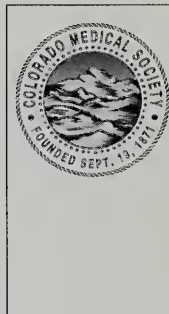
the AHA's full-time director of government affairs. Huttner formerly held the position of health policy advisor to Governor Roy Romer.

The AHA's new Public Affairs Task Force includes:

- David Badesh, MD, University of Colorado Health Sciences Center
- Lori Beisters, MD, president, The Children's Hospital
- Bernie Buscher, former director of State Health Care Policy & Financing
- Dennis Brimhall, president, University of Colorado
- Mollie Brendage, Campaign for Tobacco-free Colorado
- Phil Corsello, MD, National Jewish Center for Immunology & Research
- Joel Karlin, MD, former president of Colorado Medical Society
- Martha Kreutz, State Representative
- Dick Lamm
- Barbara O'Brien, Colorado Children's Campaign
- Bea Romer, First Lady of Colorado
- Wilma Webb, First Lady of City of Denver
- Lisa Weil, counsel to Governor Romer

The AHA is also seeking volunteers to help in local communities across Colorado with contacting legislators and other policymakers. For more information, call Michael Huttner at (303) 369-5433.

The AHA has thousands of volunteers from all walks of life who support lifesaving research, provide education and information people need to keep their hearts healthy, and raise money for research and education in our communities.



The Colorado PIP IME Program Needs You!

In 1996 the state legislature passed a law that created a method for obtaining an independent, objective medical opinion concerning care and treatment of persons injured in automobile accidents. The official title is the Personal Injury Protection Examination Program. The intent is to resolve a dispute or question regarding treatment provided. The law creates very specific requirements for the program including: 1) In most situations, only a specialist that is the same specialty as the treating physician may review such physician's treatment; 2) the IME should be conducted in close geographical proximity to the injured motorist's residence when possible; and 3) to foster objectivity, the selection of the IME physician must be done through a process of elimination from a list of five names selected through a revolving process by a contractor on behalf of the Division of Insurance.

As you can surmise, the need for physicians to be involved in this program is great. As it has turned out, the program is quite large and growing. It is estimated that over 4,000 IMEs will be performed in the next 12 months. The PIP IME panel is arranged by specialty and all specialties are needed given the breadth and depth of the program.

Northern and southern Front Range and rural areas are in great need of additional panel members. Neurosurgeons, ophthalmologists, otolaryngologists, neurologists, family practice, internal medicine and certain other specialties are significantly

cantly underrepresented on the panel.

A panel member may charge whatever fee seems fair and appropriate. Panel members are acting on behalf of the Colorado Insurance commissioner and as such are immune from civil liability in any legal action concerning their findings, conclusions and opinions rendered in the capacity as a panel member.

If you are interested, please contact Bob Husson of RMH Administrators. He will send you a complete explanation of the program and the requirements for participation and is willing to answer your questions and provide information as needed. He may be contacted at PO Box 31663, Aurora, CO 80041-1663; phone (303) 306-6370; fax (303) 306-6321.

David R. West, Ph.D. to Join RMHMO

David R. West, Ph.D. will be joining Rocky Mountain HMO as vice president overseeing the health plan's Front Range operations effective February 1. West brings more than 20 years of healthcare experience to Rocky Mountain HMO.

He is currently the chief executive officer of Colorado Access, a health maintenance organization serving primarily Medicaid clients on the Front Range and in southern Colorado. The Board of Directors of Colorado Access will begin recruitment for a new CEO immediately. The Board will conduct a national search for the new CEO and hopes to fill the position by July 1, 1999. West previously served as state Medicaid director in the Colorado Department of Health Care Policy and Financing and as health planner/researcher in the Colorado Department of Health and for Blue Cross and Blue Shield of Colorado.

Rocky Mountain HMO is a nonprofit health plan founded in Grand Junction in 1974. The HMO currently serves approximately 94,000 individual, employer group, Medicare and Medicaid members throughout Colorado. Rocky Mountain HMO is the principal HMO partner of the Colorado Physician Network (CPN).



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BOULDER-EXCELLENT OPPORTUNITY for Board Certified MD in Urgent/Family/Occupational care. Reply to Medical Director, Meadows Medical Center, PC 4800 Baseline, D-106, Boulder, CO 80303. (303) 499-4800. 04/1098

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SEEKING BC/BE GENERAL OPHTHALMOLOGIST for association/buy-out of established solo practice in Western Colorado. Please send CV and letter of interest to Nicholas Cole, 830 S. Fourth St., Montrose, CO 81401 06/1098

FULL & PART TIME OPPORTUNITIES AVAILABLE IN FORT COLLINS, 4 physician IM practice. Moderately sized community listed as Americas best city to live. Income guarantee. Fax (970) 224-1210 or phone practice manager (970) 224-9508. 1100 Powder River Dr., Fort Collins, CO 80524 01/1198

DENVER, CO - Very successful clinic in Southwest Denver needs B/E, B/C Family Practice physician with OB ASAP. OB is a must. Exp. 1 to 10 years. Comprehensive benefits package. Call is 1 in 3. Call Sullins & Associates at (303) 986-1909 or fax CV to (303) 986-1509. 01/1298

DENVER-B/E, B/C DERMATOLOGIST GENERALIST - needed ASAP for MSG. No Call. Highly competitive salary and benefits. Call Barry at Sullins and Associates (303) 986-1909 or fax CV to (303) 986-1509. 01/1298

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LOCAL COMMUNITY HEALTH CENTER seeks an energetic BC/BE FP with OB skills desired; flexible hours. Limited supervisory call. Loan repayment possible please call or send CV to Michael Barris, MD Pueblo Community Health Center 110 E. Routt, Pueblo, CO, 81004 or call (719) 543-8718 ext. 117 or 120 for further details. 03/1298

DENVER-B/E, B/C GENERAL SURGEON needed for large MSG complex. Competitive salary and benefits. This is one of Denver's premier complexes. Call Barry at Sullins & Associates (303) 986-1909 or fax CV to (303) 986-1509. 01/1298

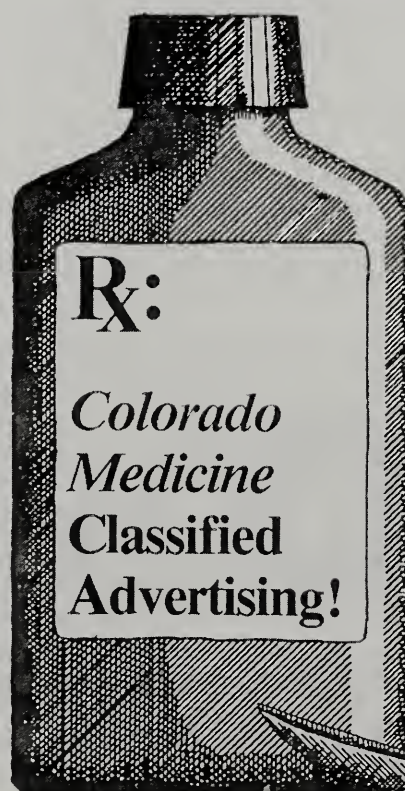
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For more information call Brian D. Smith P.C. Mr. Smith specializes in the Medical Arts. (303) 832-3666. 11/0998

STROKE NEUROLOGIST EXPERIENCED in setting up acute stroke treatment programs, stroke clinical pathways, and stroke units. Reply to Box 6 at P.O. Box 17550, Denver, Colorado 80217-0550. 03/1198

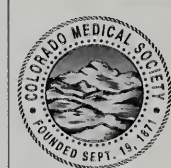
PRACTICE MANAGEMENT SOFTWARE Firm Seeking Local Beta Site - Boulder, CO based software firm is seeking second beta site to test Internet based practice management software. Modules include scheduling, point of care and billing which are currently installed at an 85 physician multi-specialty practice. For more information please contact Laila at (303) 444-4370 x118. 01/1298



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CPHP

Colorado Physician
Health Program

Dedicated
to

Physician Peer
Health Assistance

899 Logan Street
Suite 410
Denver, CO 80203
303-860-0122
1-800-927-0122

CPHP serves the needs of the Colorado medical community through problem identification, treatment referral, monitoring, clinical consultation and support to individuals and their families.

Physicians who may be experiencing physical, emotional, or psychological problems may elect to refer themselves for evaluation. Family members, colleagues, or other concerned individuals may also provide a referral for a physician in need of assistance.

The Colorado Physician Health program is a non-profit organization established by the Denver and Colorado Medical Societies. These physicians recognized that organized medicine had an important role in physician health: identifying and providing confidential assistance to physicians with medical, psychiatric or emotional problems in the interest of their own and their patients well being.



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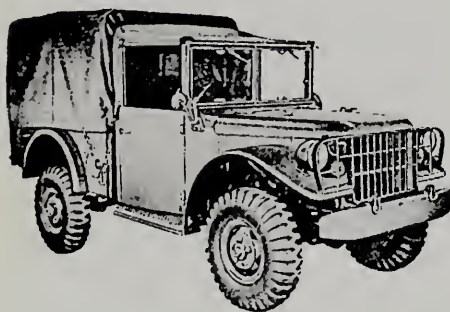


RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

Bill Pierson
Managing Editor

*I am tired of seeing,
hearing and reading
about "Y2K."*



I am tired imagining "**total shutdown**" prospects because most computers on earth can not distinguish time and dates correctly.

Am I oversimplifying? I don't think so. If only simplification could happen in our world today. I like simple; I have even been accused of being "simple-minded" (the accuser being in a fit of peak over some **simple** thing).

My principal hobby for years has been tinkering with my ex-Army vehicles, the "M-37 & M-43"; they are a classic conglomeration of "**simple but effective**." These 4-wheel-drive trucks (weighing over 7,000 lbs. empty), are so simple that to work on any part of the truck requires only a set of standard open-end wrenches, pliers, a couple of screwdrivers, a can of penetrating oil and no fear of frustration.

When operating properly, these trucks will go up or down a mountain at up to a 45° angle, pull tree stumps, move boulders, plow snow, operate under water to a depth of 4½ feet, travel at a determined top speed (crawl) of 1.5 m.p.h. when in 4WD, compound low.

Vehicle maintenance requires no computer analysis or computer anything. There is a manual (with pictures) that will guide you through taking the truck completely apart. When you want to work on the engine you can literally climb into the engine compartment and see virtually every engine component to adjust or remove without breaking knuckles or backs. Under the truck on a "creeper" (a low dolly on which you can lie while reaching up under a vehicle) you can work without bumping your head or nose.

Naming the vehicles is quite appropriate, but no vanity license plates, please. My two are named "Dwight" (in memory of Dwight D. Eisenhower) and "Vern" (just because I like "Vern"). Names are also handy when you work on and have to talk to the trucks.

My appreciation for these vehicles began in the Army when the truck seemed to be the only friend I had. I decided the Dodge "M-37" (an outgrowth of the first military Dodge "**PowerWagon**") was the best all-round vehicle ever made, and if I ever had a place to use such a vehicle, I would have one. Since my back yard is almost straight up I decided that the M-37 would be right at home. And one of them has been for the past 15 years.

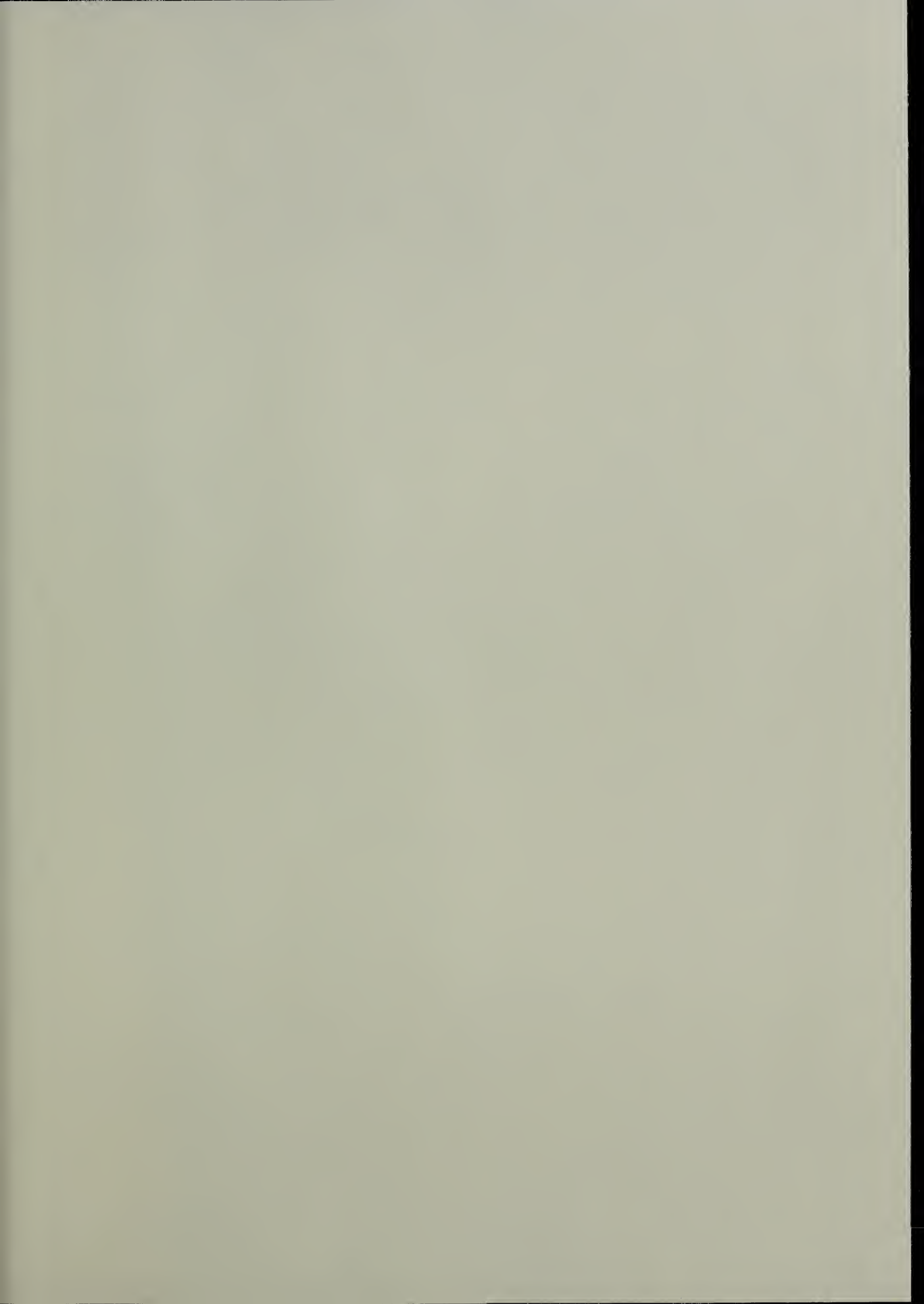
Back to basic simplicity: the prospect of computers running our lives is not a threat to younger (even very young) people. My 3½ year old grandson has already picked up the manipulation of interactive programs. For the older citizen who has no computer experience, this can be a daunting thought; e.g., programming a VCR or resetting a digital clock which is an integral part of your **automobile am/fm/cassette/CD player/clock cluster**. Instructions say push a button which, by label and definition, can have absolutely nothing to do with reprogramming a VCR or a clock. This sort of thing is enough to paralyze anyone!

Back to the future (Y2K): The millennium is NOT the year 2000. At least in my book it isn't. 12:01 a.m., January 1, 2001, is the beginning of the new century. I have seen advertisements touting Year 2000 as the beginning of the "new millennium". The two events should not be confused. Year 2000 has swelled in importance only because something is liable to happen to your lifestyle if your computer chips haven't been cleaned and adjusted to see beyond **99**. Yes, the **end** of the 20th century occurs in the year 2000.

I remember some years ago when the late Dr. Fred Lewis bought a new car. It was a sporty convertible, and I asked him one day if he was trying to recapture a more youthful time. He said no, he had always liked convertibles and this one was certainly an older man's convertible: it made him feel sporty when a computerized female voice reminded him of low fuel, seat belts, headlights, ignition keys, etc.

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NOT TO CIRCULATE

NOT TO CIRCULATE

